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## **THE VOLUNTARY CITIZEN**



THE  
VOLUNTARY CITIZEN  
AN ENQUIRY INTO THE PLACE OF  
PHILANTHROPY IN THE COMMUNITY

*by*  
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TO THE MEMORY OF  
MY MOTHER  
JANET MORLAND BRAITHWAITE  
AND TO  
MY FRIENDS  
G. JEBB  
DIANA M. LALL  
GEORGE PEVERETT





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*July 1938*



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# INTRODUCTION

## THE ANGLE OF APPROACH TO THE SUBJECT

I STARTED on this enquiry into the place of charity and voluntary social service in the life of the community with the combined interests of a student of the social sciences and of a citizen concerned for social reform. I was impressed by the scarcity of published work giving either collected information about philanthropic activities in this country or a discussion of the distinctive nature of these activities. When I started on my research the latest published work treating the subject from my angle of interest was B. Kirkman Gray's 'Philanthropy and the State,' published posthumously in 1908, and I here acknowledge my debt to this book as a source of inspiration in my enquiries. During the period of my research, in 1934, Miss Elizabeth Macadam published her book, 'The New Philanthropy: A Study of the Relations between the Statutory and Voluntary Social Services.' This book absolved me from any obligation which I might otherwise have felt to make a general survey of the whole ground of philanthropic effort. My book, therefore, is divided into three Sections, treating the subject from three different angles of approach, but with an attempt to relate these angles. Section I is described as 'an essay in social philosophy' and is a discussion from my personal standpoint of the essential nature and importance of philanthropic activities. Section II assembles the available information on the income of all organized charities and attempts to assess the financial importance of charity. Section III is a detailed study of district nursing associations as an example of a social service organized and provided by voluntary charitable associations. In both Section II and Section III the trends in recent years are discussed as well as the present position.



The whole of this enquiry is concerned with the distinctive features of philanthropy. Therefore it does not include discussion of many conditions and problems common to both public and voluntary finance and administration of social services. For example, there is no discussion of the problems of the effects of the social services on those benefiting from them nor of the conditions of training and employment of paid social workers.

#### A NOTE ON PERSONAL BIAS

The whole of Section II and the whole of Section III (except the last chapter—Chapter XVIII) are treated as objectively as possible, without the introduction of my personal opinions. Section I contains an assessment of values as well as a discussion of facts and the whole of that Section is written from my personal point of view.

#### A NOTE ON DEFINITIONS OF TERMS

Unfortunately the terms used in connection with philanthropic activities have, with the passage of time, acquired somewhat derogatory meanings. This is true of the terms 'charity' and 'philanthropy,' and it is probably becoming true of 'social service.' But, unless I invent a completely new terminology, which would be incomprehensible to the reader, I must use these terms. Needless to say I use them free from any derogatory connotation.

The term 'charity' is used throughout this book to include all voluntary gifts of money (or its equivalent in goods) for purposes which are of no direct economic benefit to the donor or his immediate family dependants. Thus the term excludes all contributions to taxes or rates because these are compulsory, and it excludes all contributions of members to compulsory or voluntary insurance schemes because these schemes secure certain definite economic advantages to the contributors.

The terms 'voluntary social service' and 'voluntary personal service' are used interchangeably to include all voluntary

unpaid personal service rendered by an individual to other individuals or groups except that rendered to his family and personal friends. The terms include voluntary unpaid personal service to both voluntary organizations and public bodies.

The term 'philanthropy' is used to include all that is included in both the terms 'charity' and 'voluntary social service'.

The terms 'a charity' or 'charities' and 'a voluntary social service' or 'voluntary social services' are used interchangeably to include all voluntary organizations providing any form of social service, except those which are regarded as forms of mutual insurance. Thus the terms include all that is included in the legal definition of charities (except that in some parts of the discussion purely religious organizations are excluded). The terms also include voluntary organizations for propaganda.

None of these definitions is watertight but they correspond fairly well with ordinary usage except for the inclusion of propaganda organizations as charities.

The term 'the State' is used to include local authorities and *ad hoc* public bodies.

The term 'interest' as a class of receipts of charities is used to include all forms of income from property.

The whole of Sections II and III are confined to conditions in England and Wales. Scotland is excluded for the reasons that I have no personal knowledge of Scottish conditions and problems, and that an attempt to include information and statistics for Scotland would have added considerably to the difficulties of the enquiry. In Section I much of the discussion is of wider scope, but even there I am concerned mainly with conditions in Britain and have made no attempt to discuss conditions and problems in other countries.

#### A NOTE ON SOURCES OF INFORMATION

For Sections II and III the sources of information are indicated in the text and a list of references is given at the end of the book. A list of the main references for Section I

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is given at the end of the book. Throughout the enquiry I have derived information and opinions from so many sources that it is impossible to mention them all. Much has been derived from conversations of both a formal and informal kind.

## **SECTION I**

### **PHILANTHROPY AND CITIZENSHIP: AN ESSAY IN SOCIAL PHILOSOPHY**



## CHAPTER I

### THE CASE FOR PUBLIC SOCIAL SERVICES

#### INTRODUCTION

THIS Section is an attempt to make an evaluation of philanthropy: it discusses what should be the place of philanthropy in the community. Unlike Sections II and III of this book, which (except in Chapter XVIII) will treat their material as objectively as possible, this Section does not treat its material objectively but assembles facts in illustration of my personal philosophy of philanthropy

In my attempt to evolve a philosophy of philanthropy I have tried to synthesize elements in my experience of social life which appear to be somewhat contradictory. As an economist I have found that economic theory gives very little attention to philanthropy, and considers only the self-regarding economic activities of individuals or groups and the economic activities of public authorities. This does not seem to reflect truly the importance of philanthropic activities in the lives of many individuals. As an individual concerned for social reform I have been impressed both by the helplessness of philanthropy in face of some of our most urgent social problems and by its immense value in experiment, in propaganda, and in its educational effects on the participants. As a citizen I have been conscious of the superiority of State action over philanthropy in its universality of provision and democratic spirit, but I have also been conscious of the defects of State action in excessive standardization, inadequate reflection of minority opinions, and limitation of geographical scope. The implications of these contradictions will be developed in various parts of this Section.

Although the principles of philanthropy are being constantly discussed in many circles, both orally and in articles and reports, there have been very few books on the subject

published in this country Since the publication of B Kirkman Gray's 'Philanthropy and the State' in 1908 the main books have been Miss Hilda Jennings' 'The Private Citizen in Public Social Work' (1930), Miss Elizabeth Macadam's 'The New Philanthropy' (1934), and a group of books by members of the Charity Organization Society—C S Loch's 'Charity and Social Life' (1910), Helen Banquet's 'Social Work in London, 1869 to 1912' (1914), and the late J C Pringle's 'British Social Services the Nation's Appeal to the Housewife and her Response' (1933) There is also available an unpublished thesis by Miss L. H Bell entitled 'The Respective Spheres of the State and of Voluntary Organizations in the Prevention and Relief of Poverty in London at the Present Day' (1935) (Since this was written the present-day views of members of the Charity Organization Society have been published in the late J C Pringle's book, 'Social Work of the London Churches' (1937), and have also become available in two collections of recent articles in volume form entitled, 'Beliefs of the London Charity Organization Society, 1930-37' and 'The Mother in her Home' Two other recently published books also contain discussions of the philosophy of philanthropy—Mr T S Simey's 'Principles of Social Administration' (1937) and Mr J Q Henriques' 'A Citizen's Guide to Social Service' (1938) )

For a long period the Charity Organization Society have had the distinction of producing almost the only systematic body of philosophical thought on the subject of philanthropy There have been other isolated writers, but the schools of thought not in agreement with the Society have not produced any considerable body of alternative theory (The main exception to this statement is the Minority Report of the Royal Commission on the Poor Laws of 1905-09 There are also several incidental discussions in the works of Mr and Mrs Sidney Webb ) Thus for a student of the subject like myself, who is both interested in the philosophy of philanthropy and in disagreement with much of the general social theory of the Charity Organization Society, there is ample stimulus to attempt to construct some parts of an alternative theory.

The arrangement of subjects in this Section is as follows

This chapter states the general arguments in favour of financing certain types of social services from public rather than charitable funds, and discusses the implications of these arguments with special reference to the relief of poverty and the health services. Chapter II describes four spheres in which there is scope for charitable effort because, for various reasons, the State cannot act adequately in those spheres. Chapter III discusses the place of the voluntary social worker and the voluntary administrator in both voluntary and public social services. Chapter IV speculates as to the place of philanthropy in a socialist community and discusses to what extent the ideals and methods of socialism are compatible with those of philanthropy. The last chapter gives a short summary of the argument of the whole Section.

It should be noted that all the descriptions of particular social services given in this Section are used merely as illustrations of the principles discussed, and are not intended to be adequate summary accounts of those services.

### THE MOTIVES FOR SOCIAL SERVICES

All social services, whether public or voluntary, are concerned with meeting the needs of individuals or groups who are not able to meet these needs adequately from their own resources. The motives for the social services have varied in different types of service and at different periods, but there seem to be four main types of motive responsible for our present public and voluntary social services.

(1) The mainspring of philanthropy has usually been the emotion of pity and sympathy with distress of all kinds. This emotion is felt to some extent by nearly every one, but it varies greatly in different individuals with regard to the kinds of distress which most easily arouse it, with regard to its efficacy as a motive for action, and, most important, with regard to the size of the group over which it is extended. The sympathy of some people seems to be confined to those with whom they have come into personal contact, and it is thus completely inadequate to deal with the problems of a civilization in which the welfare of individuals is often dependent upon the actions of persons and groups whom they



will never meet, perhaps at the other side of the world. A great deal of charity and voluntary social service is given directly by one person to another, without resort to any organization. The fact that it is impossible to compute its amount, or even to know anything about most of it, does not detract from its immense importance in social life. It is the spontaneous expression in direct personal intercourse of the same emotions which are evoked for wider use by philanthropic organizations and public authorities.

(2) A second motive for social services is the conviction that all individuals in a certain group are 'members one of another'—I shall term this conviction the sense of community. This sense of community is related to a feeling of sympathy for other members of the group, but the two sentiments can often be distinguished. In so far as the sense of community is a reasoned conviction, it is based on a realization of the facts of economic, social and cultural interdependence. The sentiment is attached to many kinds of groups; one of its strongest expressions is in national patriotism, and it has been very important as a motive for State social services.

My personal sense of community is much affected by a realization of the economic interdependence of individuals and groups, both within the national community and throughout a large part of the world. Because of this economic interdependence, I regard the philosophy of economic individualism as being based on false factual premisses. We cannot leave the individual to work out his own economic salvation, because the main circumstances affecting his economic position are outside his individual control. The individual cannot determine the main circumstances affecting his wages and the regularity of his employment. The circumstances of his education and upbringing are obviously not determined by him, and many of them cannot be controlled by his parents. If this view is adopted it follows that it is not necessarily a check to the self-reliance of the individual for the State or other associations to control deliberately on his behalf circumstances which he cannot control individually. The controlling or assisting agency will have to consider the probable effect of measures of various kinds on the energy and enterprise of those affected, but it need not assume that those

needing assistance are, because they need assistance, personal failures. It follows also that measures of control or taxation affecting adversely the economic position of the well-to-do can also be judged on their own merits, as the position of the well-to-do is largely the result of general social circumstances rather than of their individual actions.

(3) The provision of certain social services has been inspired by ideals of equality. The idea that 'all souls are equal in the sight of God' is part of the Christian tradition, and this conception has markedly influenced some forms of provision. The early nineteenth-century movement for popular education was partly inspired by the belief that every one had the right to be able to read the Bible, and this belief in another form is responsible for much of the work of foreign missionary societies. A desire for equality before the law is a motive for the work of Poor Man's Lawyers. A belief in educational equality has been a motive for the educational provision made by both charitable donors and associations and by the State. The work of charitable organizations has probably not been greatly influenced by belief in economic equality, but this belief has certainly influenced the State provision of social services.

My personal view on equality is that the large inequalities of wealth and social position existing at present are most undesirable. The community should aim at educational and social equality and at much greater equality of income. Only such inequalities of income are justified as are necessary to act as incentives to work and as regulators of the numbers of workers in different occupations and industries, and these purposes could be served by a much smaller range of inequality than exists at present.

(4) A motive for social services which has become very important in recent times is the motive of economy, using the term in its widest sense. People have become increasingly aware of the waste of potentially useful human resources involved in illness left uncured, children left uneducated, offenders left at enmity with society. The importance of the motive of economy is fairly recent because in many cases the knowledge necessary for effective action has been acquired only in recent times, for example, many diseases are

curable which were regarded as incurable a hundred years ago. The social services of public health work and education result in increased economic productivity, but, as the gains accrue largely to the individuals aided, not to those providing the service, such services are never adequately provided on a profit-making basis.

### THE RELIEF OF POVERTY

The present public social services are divided into two main groups, the unspecialized service of the Poor Law, available for all who are ' destitute ' and only for such persons, and a great variety of specialized services or services for special groups of persons, some of them available for all who care to use them, and some of them available only for those below certain levels of income, which vary with the different services. The Poor Law is by far the oldest of the public social services and existed for more than two hundred years in solitary splendour. At the time of the Poor Law Amendment Act of 1834 it was still the only provision made by the State for the relief of poverty. Since that time a number of specialized services have grown up, some of them providing direct services but not money income, for example, the public education and public health services, some of them providing incomes outside the Poor Law in particular classes of need, for example, old age pensions and unemployment insurance. The Local Government Act of 1929 and the Unemployment Act of 1934 have made it possible to remove other classes from the purview of the Poor Law. But the Poor Law still deals with a large number of persons, as there have been other circumstances counteracting the effects of increasing provision of alternative methods of relief. One of these circumstances has been the rise in the standard of what should be guaranteed by the State as a minimum subsistence and concurrently a more generous interpretation of the term ' destitution '. The alternative forms of provision do not by themselves provide adequate incomes in many cases, and the Poor Law is used to supplement them. Another circumstance has been the large amount of unemployment existing ever since 1921. Though the large majority of the unemployed at any one time have been covered by the Unemployment Insurance Scheme

and other special schemes of assistance for the unemployed, considerable numbers, particularly in certain depressed areas, have fallen outside these schemes and have obtained relief from the Poor Law. This position, however, will not continue now that the Unemployment Act of 1934 has come into full force, as these persons will receive relief from the Unemployment Assistance Board.

There does not seem to be much doubt that at the present time charity is of very little importance, compared with the public social services, in the relief of poverty outside institutions. If the total amount spent is taken as evidence this statement is borne out by the figures given in Chapter XI, Section II (see pages 179 and 184). Miss L. H. Bell, in her thesis referred to earlier in this chapter, supports this conclusion from a study of the actual relief work of public and voluntary agencies in London. She says, 'Charity is very largely engaged in giving supplementary forms of help, while the great majority of those who have to face really serious economic difficulties must look to the State for assistance.' In another place, in analysing a sample of cases dealt with by district committees of the Charity Organization Society, she notes that only in a very small number of cases can maintenance outside an institution be obtained from voluntary sources. The most important exception is the help given by the ex-service men's funds, but 'Committees concerned in dealing with men who have not had War service normally look to the Public Assistance Committee to provide maintenance in cases of temporary difficulty as well as in cases of chronic poverty.'

Thus with regard to the bulk of the domiciliary relief of poverty we have reached the position when it is undertaken by the State, not by charity. I approve of this position and should like to see public provision extended so that all charity for the purpose of relief of actual poverty becomes unnecessary. (Charity for this purpose is not thought unnecessary at present, as is evidenced by the large amounts still spent by charities giving 'general relief' (see Chapters VII and VIII in Section II).) There are, however, a number of serious difficulties which stand in the way of the complete supersession of charities for the relief of poverty.

One of these difficulties is in process of disappearing—the repugnance felt by many people to appealing for help to the Poor Law. This repugnance is, of course, partly the deliberate creation of the Poor Law Authorities, who for a long period pursued the policy of making poor relief disagreeable in order to keep down the number of those applying for it. This principle of deterrence has been much modified in the post-War period, but there are still relics of it existing. I regard a repugnance to relief by the Poor Law, compared with relief by charity, as being unreasonable. If the destitution of the applicant is due to his own misdeeds he has as much reason for shame in applying to charity as in applying to the Poor Law. If his destitution is not his fault he has no reason to be ashamed in either case (though, as long as our worship of wealth continues, he often will be). In fact he should even feel less aversion to being helped, in time of need, from a fund to which, in better times, he has contributed as a ratepayer than to being helped from a fund entirely provided by others.

A second difficulty is that people differ greatly in their definition of poverty, and many charitable people may regard the standard of relief given by public authorities as being too low, either in general or in particular cases. If the standard is too low, the logical thing to do is to try to get it raised, but failing this, it is difficult to argue that charitable individuals or charitable societies should not supplement public provision in cases which are brought to their notice. (This must be done in such ways that the public authority does not merely deduct from its relief the amount given by the charity.) However, the charitable donors concerned should realize that they can help only a small proportion of those left inadequately relieved, and they should regard their charity as but a makeshift until such time as public authorities shall make adequate provision. With regard to the giving of charity to meet needs which are not absolute necessities there is much more to be said in favour of charity. This point is discussed in the next chapter under the heading of 'Supplementary Charities,' and it is pointed out there that, with the existing differences of income and standards of living, there will be many cases in which charitable individuals may wish to provide for persons

in a certain group a standard of income, or of services of various kinds, higher than that provided by the State for the population as a whole

The third difficulty standing in the way of the superseding of charity for the relief of poverty is much more serious. It is the fact that public authorities cannot adequately relieve poverty without dealing with certain more general economic conditions. The two general conditions which mainly affect the problem are the lowness of the earnings of many workers, especially when in irregular employment, and the prevalence of long-period unemployment.

The lowness of the earnings of many workers makes it difficult to provide adequate maintenance in times of sickness and unemployment because such a scale of maintenance would equal or exceed the income of the recipient when in work. It is generally thought that to provide adequate maintenance in such cases would put too great a strain on the individual's will to work, and this is certainly true in some cases. The problem is the same whether the relief is given by charity or by the State. Good case work methods and freedom from rules, so that a discrimination can be made according to the reactions of the individual case, are advantages possessed by some charitable organizations, though not by all. The measures desirable in order to raise the wages of low-paid workers and regularize their employment lie outside the field of the social services. But there is one possible extension of the social services which would do much to alleviate the poverty due to low-paid and irregular employment—a State scheme of family endowment. I am strongly in favour of such a scheme for reasons which lie outside the scope of this book. A State scheme of family endowment would presumably provide full or partial maintenance for the child from the time of birth until a certain age was reached, irrespective of whether its parents were alive or dead, healthy or ill, in work or unemployed. It would thus very much lessen the difficulties involved in the comparative economic positions of the family supported by earnings and the family supported by State assistance, as it is in the case of large families that adequate State assistance is most likely to exceed the amount normally earned by the wage-earner. The effect of a scheme

of family endowment which provided sums equal to or approaching the cost of maintenance of children would be to make unnecessary a good deal of the provision now made by both charity and the State. For example, in the public social services, free school meals would become unnecessary, though school meals for which payment was made by the parents might be continued for reasons other than the relief of poverty. A considerable amount of the work of charities on behalf of children would become unnecessary. For example, there would probably be a decrease in the work of children's Homes, though in a good many cases poverty is only one of the reasons for the admission of the child to the Home. In any case the amount of the State allowance for the child would be available towards the cost of its upkeep in the Home, and the amount required in charitable gifts would decrease.

The second general economic condition which prevents public authorities from adequately relieving poverty, is the prevalence of long-period unemployment. The Unemployment Insurance Scheme is adapted to the assistance of individuals unemployed for short periods, when the amount of the benefit can be supplemented by savings, by gifts from relatives and friends, by running up debts, and by postponing certain kinds of expenditure. It is not adapted, either as an insurance scheme or in the scale of benefits, to the unemployment continued over years which has been the fate in most of the post-War period of many workers, especially in the depressed areas. The position has been much better than it would have been had the scheme not existed, and the scheme has recently been supplemented by the provision of assistance under the Unemployment Assistance Board. But neither the present nor any possible public or voluntary social services can deal adequately with the unemployed, because the evil lies in the existence of the unemployment and nothing will cure it short of the provision of work and wages.

My conclusion is that the relief of poverty should be the responsibility of the State and not of charity, but that charitable relief will and should continue as long as poverty exists which is not adequately relieved by the State. The adequate relief of all cases of poverty by the State is very difficult to establish without the change of certain general economic

conditions—the low and irregular earnings of many workers, the failure of the present system of distribution of income to make any direct provision for the maintenance of most children, and the existence of long-period unemployment

### THE HEALTH SERVICES

Although the provision for health services has increased very greatly during the last thirty years and although it is now assumed that no one should be deprived of essential medical and nursing services on account of poverty, our provision is made by a variety of systems with little co-ordination between them and with insufficient provision for many types of case

Any person who is 'destitute' is legally entitled to receive domiciliary medical services under the Poor Law, and institutional medical and nursing services in the hospitals under the control of the local authority. Destitution is now interpreted as meaning not necessarily complete destitution but inability to provide the necessary medical services without public aid. Domiciliary medical service is usually provided by a system of 'poor law medical officers'—doctors who are engaged in poor law work either full time or in combination with other work for public authorities or with private practice. Any destitute person has the right to the medical services of the officer in his district. (In a few areas arrangements have recently been made for the destitute person to make his own choice of doctor.) A defect of this system is that its association with the Poor Law has tended to deter those in need of medical advice and treatment from making use of it except in cases of urgency or in cases where the persons concerned are already receiving other forms of poor relief. As will be explained in Section III, provision under the Poor Law includes provision for domiciliary nursing, but this has nearly always been provided not directly by the Poor Law authority but through district nursing associations.

Institutional treatment under the Poor Law is provided in special institutions which are sometimes separate hospitals or infirmaries and sometimes sick or infirmary wards of general poor law institutions. Under the Local Government Act,



1929, it is provided that the Poor Law authorities—counties and county boroughs—may transfer their institutions for the sick from administration under the Poor Law to administration under their Public Health Committee, and may administer them as general public hospitals available for all in need of hospital treatment. In the County of London and in many county boroughs institutions have been transferred in this way, but such transference has been exceptional in county areas. It is now true in general that any person needing hospital treatment and unable to obtain it in any other way has the right to treatment in either a Public Health or a Poor Law hospital, but any reluctance to accept such treatment is likely to be less in those areas where the public hospitals have no association with the Poor Law.

A considerable amount of non-institutional medical service is provided by charities, especially the out-patient departments of voluntary hospitals and charitable dispensaries, in areas where these latter exist. All persons insured under the National Health Insurance Scheme have the right to the free services of a general practitioner for consultation and attendance in the home and also the right to free provision of any medicines prescribed by him. Thus a considerable proportion of the adult population are provided with ordinary medical services without recourse to either the Poor Law or charitable agencies, but the provision does not, in most cases, cover specialist services nor institutional treatment. The Scheme does not include independent workers, whose incomes are often no greater than those of wage-earners, nor does it include the dependent wives and children of insured persons. There is no public scheme, other than the Poor Law and maternity services, which provides domiciliary medical treatment for married women who are not themselves employed persons. If such married women need the services of a doctor in the home they must pay for these services privately or through voluntary insurance or they must apply to the Poor Law or to charitable agencies. With regard to children much medical advice and treatment is provided by the infant welfare and school medical services, but neither of these services includes medical attendance in the home. It would be a great improvement if the National

Health Insurance Scheme were extended to include the provision of 'medical benefit' (i.e. the services of the doctor and medicines) for the dependent wives and children of insured persons (This extension was recommended in 1926 in the Minority Report of the Royal Commission on National Health Insurance. It was also recommended in the British Medical Association's 'Proposals for a General Medical Service for the Nation' (1930), and in the P.E.P. (Political and Economic Planning) 'Report on the British Health Services' (1937)). Such an extension of 'medical benefit' would probably result in a considerable decrease in the demand for certain forms of charitable provision, for example, for some of the services of the out-patient departments of voluntary hospitals.

Nearly all the institutional provision for mental illness and infectious diseases, and a considerable proportion of the institutional provision for tuberculosis is made by public authorities. In the institutional treatment of general medical and surgical cases there is a great deal of provision made by voluntary hospitals as well as by public authorities. Voluntary hospitals have a long history of very valuable service both in the treatment of illness, in which their provision was for a long period much superior to that made by public authorities, and in medical research and the training of doctors and nurses.

It is obviously impossible for any one without medical knowledge to examine in detail the comparative advantages of public and voluntary hospitals, but there are certain general considerations which can be put forward.

(1) In the first place there is now no great distinction between the types of work done by public and voluntary hospitals in large urban areas. The efficiency of public hospitals has greatly increased, and, in many areas, particularly where such hospitals are not administered under the Poor Law, they are used by all sections of the population except the well-to-do, in the same way that the voluntary hospitals are used. The public hospitals tend to have a larger proportion of chronic and incurable cases, and this is particularly true in rural areas. Both types of hospitals are used for the training of nurses, but it is still exceptional for public hospitals

to be used for the training of doctors. The types of work done by public hospitals vary in different areas in relation to the abundance or scarcity of voluntary hospital provision in the area—where there is adequate voluntary hospital provision the public hospital tends to deal only with those types of case not undertaken by the voluntary hospital, where there is inadequate voluntary hospital provision the public hospital deals with all types of case.

(2) A considerable number of patients in both types of hospital now pay part of the cost of treatment, and in the voluntary hospitals there has been a large increase in such payments in recent years. Payment is made either by the individual patient at the time of treatment, according to his means, or by contributions to voluntary hospital contributory schemes, which are now widespread. Thus with regard to many patients public or charitable funds are subsidizing the service, not paying the whole cost, though the total amount of patients' payments is much greater in proportion in the voluntary hospitals than in the public hospitals. (See the figures in Chapter XI, pages 171 and 180.)

(3) There is no doubt that the voluntary hospitals benefit from the small charitable gifts of very large numbers of the population, though they also receive individual large gifts, particularly for capital purposes. This widespread financial support is a great source of strength of the voluntary system, but it also means that the support of these hospitals from taxes and rates would meet with the approval of the tax- and rate-payer—or at least with as much approval as he gives to any other form of public expenditure.<sup>1</sup>

It seems clear that most individuals cannot afford to pay the whole cost of essential health services, even when their contributions are made in the form of payments to compulsory or voluntary insurance schemes. It seems also clear that the State now accepts the responsibility for making the necessary financial provision for these services, when such provision is not made by charity. On grounds of general principle I think that the State should pay all the costs of health services except those which can be afforded by the beneficiaries. Good health is such an important condition of both the happiness and the full usefulness of individuals that it seems

strange that the State should leave to the chances of voluntary enterprise any of the necessary means for its attainment. As will be shown in Chapter IX, the total receipts of the voluntary hospitals have increased steadily during the past decade, and while much of this increase has been caused by the increase of payments by or on behalf of patients, there has been no drop in the total receipts from charitable gifts. Yet many hospitals are prevented by scarcity of funds from giving the most efficient service of which they are capable and desirable conditions of employment to their staff. The progress of medical knowledge has increased the cost of many types of treatment and it has also made hospital treatment desirable for a larger proportion of cases. It is no condemnation of the voluntary system to say that the progress, both in medical knowledge and in the public conscience on health matters, which it has stimulated, has resulted in demands being made upon it which it cannot adequately fulfil. It is argued in the next chapter that one of the most important spheres for charitable enterprise is in the initiation of experimental services which are taken over by public authorities when their usefulness has been established. There are still some hospitals whose work is in this experimental stage, but the work of most voluntary hospitals is of a kind which is recognized as essential by the whole community, and there seems to be no good reason why charity should continue to bear the burden, especially as there are many desirable fields for charitable effort in types of work which the State is unwilling to undertake.

If we consider the present position of the health services in this country the complete assumption of financial responsibility by public authorities does not seem to be urgent. But it is urgent that public authorities should consider themselves responsible for ensuring that adequate provision is made either by themselves or by voluntary organizations. Where provision in any area is inadequate in either quantity or quality they should extend their own services or subsidize the services provided by voluntary bodies, and the many excellencies of charitable effort in the past should not deter them from doing this. Furthermore, the provision made, whether public or voluntary, should be available to all classes

of the community the classification of institutions and services should be made on medical grounds, not on grounds of income. On the one hand there should be no special type of service for those falling under the Poor Law, on the other hand services should be available to the middle class and well-to-do provided that they contribute according to their means, up to the full cost of the service. Recent developments in both public and voluntary health services have been in the direction of giving the best available service to all, irrespective of income, demanding in return payment according to financial ability. But there is still much to be done before this ideal is realized, and it does not seem likely to be achieved without a considerable addition to both the services provided by public authorities and the amount spent from public funds.

There is inevitably a close connection between financial responsibility and control of administration, but there might well be more distinction made between the two. It will be argued in Chapter III that public control need not necessarily involve the administration of a service exclusively by members of a local authority, that for several reasons it is desirable that more use should be made of the power to co-opt outside members on to the committees and sub-committees of local authorities, and that in some cases control of detail should be delegated to *ad hoc* bodies.

These arguments apply strongly to the case of the voluntary hospitals. Much of the opposition to the supersession of the voluntary hospitals is an opposition to direct administration by local authorities rather than to the substitution of public for voluntary finance. For example, the Liverpool Hospitals Commission's 'Report on the Voluntary Hospitals of Liverpool' (1935) lays great stress on the value of the present methods of government of a voluntary hospital and states, 'We do not rest the case for the maintenance of the voluntary system upon its method of finance, but upon its method of government and its method of staffing'. Voluntary hospitals benefit from the work of many members of the medical profession, not only in rendering their professional services but also in government and administration, and they also benefit from the administrative work of many interested non-medical supporters. It would be a great loss if these two

types of administrator were eliminated in a publicly financed service. It seems desirable that, when a local authority assumes financial responsibility for a voluntary hospital, it should not simply transfer the government of the hospital to one of its committees, but should make special provision either for co-opting some of the present voluntary administrators on to that committee and its sub-committees, or for leaving the detailed work of administration to these voluntary administrators while giving a financial subsidy. It seems also desirable that in many cases the administration of what are now the voluntary hospitals should be on a regional basis, as these hospitals often serve the population of several local government areas. The special relation of the teaching hospitals with the Universities would also have to be considered.

#### THE GENERAL CASE FOR STATE FINANCE OF SOCIAL SERVICES

The previous pages have considered the case for the public finance of two very important branches of the social services. The following paragraphs will discuss the general arguments for preferring public to charitable finance. (The problem of the place of the voluntary social worker and the voluntary administrator is discussed in Chapter III.)

The main reason for preferring public to charitable finance is the inadequate amount of charitable resources. It is for this reason that many social services inaugurated by charitable organizations have now been taken over by the State. For example, the Education Act of 1870 empowered local authorities to finance elementary education from the rates because the existing provision of such education by charitable organizations was not sufficient to meet the needs of all the children in the country. In the course of time what was at first the supplementary finance of local authorities and the central government has become the main financial provision for elementary education. The great advantage of charitable organization is that it responds promptly to an apparent need of any kind and is not deterred by the fact that such a need may not be appreciated by the mass of the community.

at the time. The great defect of charitable finance is that it is very rarely adequate to provide a service of any kind for the whole population—its limitations lie not in what it does but in what it is unable to do. A measure of the degree of inadequacy of charitable finance will be given in the figures in Chapter XI. There it will be shown that of the total financial burden of the social services (i.e. the expenditure on the social services from rates and taxes and from charitable gifts) probably under ten per cent. is borne by charitable gifts (see page 178), and that even in the provision of hospital services, where charitable finance is very important, only twenty-five per cent. of the total financial burden is borne by charitable gifts (see page 181). It will also be shown in that chapter that, although exact figures cannot be given, there is no doubt that the proportion of the total financial burden of the social services borne by charitable gifts has fallen greatly during the last quarter of a century.

In order that the State shall assume financial responsibility for any type of social service, it is necessary that the particular form of service shall be approved by the majority of citizens. (In cases where local authorities have optional powers a service can be given by a particular local authority if it is approved by citizens in that area.) A considerable number of services cannot be financed by the State because this condition is not fulfilled—these services provide the most desirable sphere for charitable finance, and they are discussed in the next chapter. Where, however, the majority of citizens approve of the provision of any type of service, it is my opinion that the presumption is in favour of State finance of that service, and that the service should be financed by charity only when there are special reasons which make this preferable.

There are many cases of existing social services which do not conform to this principle. For example, there is no doubt that the provision of a lifeboat service is approved by the majority of citizens, and yet it is left to be financed by charity (even though lighthouses are financed by the State). To take another example, the majority of citizens approve of the laws regarding the prevention of cruelty to children, and there seems no reason why the maintenance of inspectors to

enforce these laws should be financed by charity, even though it may be desirable that the inspectors should be employed by a voluntary organization rather than by public authorities, and that State aid should be given by the method of grants to voluntary bodies. In many cases the explanation of these anomalies is historical: voluntary associations started to provide certain services at a time when the State was unwilling to provide them, and organization has not been adapted to the changed state of public opinion.

The arguments in favour of the State finance of a particular service are greatest when the service is of an essential nature, when voluntary finance is very inadequate, and when the total expenditure involved is great. These two latter points are connected, as voluntary finance tends to be most adequate when the total necessary expenditure is not large. For example, the much smaller total expenditure necessary for the service of district nursing is one reason why charitable finance is much less inadequate than in the provision of hospital services. There are some types of social services in which the most important element is the voluntary work of individual social workers, and in which the amount of expenditure necessary is not great. This is true of the work of many advisory, educational, cultural, and recreational organizations and, where such organizations are not seriously hampered by financial difficulties, there is not a strong case for State finance, even when the work is of a type approved by the general public.

My general conclusion is that the inadequacy of charitable finance should never be allowed to restrict either the quantity or the quality of any social service of which the provision is recognized as desirable by the majority of citizens. The function of charity is to demonstrate the desirability and practicability of particular forms of services until such time as the State is willing to finance these services. When public opinion has been converted to approval of such services the time has come for the pioneers to transfer the financial burden to the whole body of citizens. The charitable resources released can then be used to support types of service which the State is unwilling to finance, and to engage in further pioneer work for the education of future public opinion.



The problem of the substitution of public for voluntary finance is much complicated by the fact that many social services are financed and administered not directly by the central government but by local authorities. Local authorities vary greatly in both their ability and their willingness to finance and administer social services. For this reason it may well be the case that a particular form of service would be more adequately provided by public authorities than by voluntary organizations in some areas, while in other areas the reverse would be true. There is also the consideration that with regard to some forms of service the area of the local authority is not the best unit of provision, while voluntary associations are free to adopt the best geographical unit for the provision of the particular service. These two considerations point to the desirability of allowing different solutions of the problem in different areas and with regard to different types of service. In some cases it may be preferable for public authorities to finance a service by making grants to a voluntary organization rather than by themselves administering the service.

#### THE PERSONAL ATTITUDE OF SOCIAL SERVICE ADMINISTRATORS TOWARDS THEIR CLIENTS

There is one argument often used as a reason for preferring public to voluntary social services which does not seem to me to be valid. This argument is that charitable agencies treat their clients in a patronizing and offhand manner, whereas public authorities treat them as citizens with consideration and without any patronizing spirit. It is certainly most desirable that those in need of any type of assistance or service should be treated with consideration and respect, but such treatment is often given by charitable organizations and it has sometimes not been given by public authorities. The conditions for receipt of poor relief have often been deliberately made disagreeable as a deterrent to applicants, and there have sometimes been complaints of the perfunctory treatment of individuals by, for example, employment exchanges and 'panel doctors'.

There seem to be three main reasons for an unsatisfactory

personal attitude towards clients when this exists in either public or voluntary social services

(1) As long as our present large differences of income and social status exist the resulting attitudes of mind will tend to be reflected in the treatment of those applying for assistance. It is very difficult for individual administrators to escape entirely from the prevailing attitudes of respect for the wealthy and socially important and lack of respect for the poor and socially unimportant. It is greatly to the credit of many administrators that they do free themselves from these attitudes and treat all applicants with consideration and respect, whatever their social position. But when administrators adopt the generally prevailing social attitudes, it is not fair to blame them in particular. The existing economic and social stratification was not created by those administering social services, and in general their efforts have been in the direction of modifying it. They are much less to be blamed than other individuals, who, while accepting our system of inequality, have made no efforts to remedy its effects.

(2) The method of treatment of clients depends to a very large extent on the individual character and training of the administrator. Those who know their job best and who have also a general knowledge of social conditions are least likely to treat harshly individuals in need of any kind, and are most likely to sympathize with their difficulties. It is desirable that much more trouble should be taken to select administrators with suitable personal qualities and to give them a wide training in social work. It is desirable also that efforts should be made to enlist the services of more working-class administrators, provided that they have suitable personal qualities, as they are likely to have a greater understanding of the problems of many clients than those who have never personally experienced these problems.

(3) Many administrators are forced to deal, in a given time, with a much larger number of cases than can be treated with reasonable care and attention. The rushed nature of many interviews is responsible for much curt and offhand treatment, and for a lack of appreciation of the peculiar circumstances of individuals.

The remedy for defective personal treatment of clients

lies in the more careful selection and training of administrators, and in the provision of an adequate number of staff it lies also in general efforts by the community towards greater social and economic equality. But the problem is essentially the same with regard to both public and voluntary social services.

## CHAPTER II

### THE INHERENT LIMITATIONS OF THE STATE

#### INTRODUCTION

IN the last chapter it was argued that there is a strong case for the financing of a social service by the State when the provision of that service is regarded as desirable by the majority of citizens. But a democratic State cannot finance any service unless this condition is fulfilled, and it is not fulfilled with regard to several types of social services. In these types of service there is a strong case for charitable effort.

This chapter classifies such types of service under four headings—supplementary, experimental, controversial, and international—and discusses the work of charitable organizations providing services under these headings. Some services fall under more than one heading, but they are discussed under the heading which their peculiar features best illustrate.

#### I SUPPLEMENTARY CHARITIES

There is a considerable field for charity owing to the fact that State social services must apply the condition of equal treatment of all citizens, or of treatment varying only with differences which are considered relevant. This equal treatment is applied in a society where individuals and groups have different incomes and standards of life, and where many people feel social obligations within those groups to a greater extent than they feel them to the whole community included within the boundaries of the State.

A very good example of this field of charity is in the sphere of education. At present the State provides education for all children up to the age of 14. (The age was raised to 15 by the Education Act of 1936.) Further education can

normally be secured only by virtue of exceptional ability (public scholarships and free places), or by virtue of some payments by the parents of the young person or by others on his behalf. Charity supplements the State provision of education by providing or subsidizing types of education other than those provided by the State for children and young persons of all ages, and by providing post-primary education for those who do not obtain it by virtue of either exceptional ability or the payments of their parents.

Probably the best example of the provision of other types of education is the 'public schools' with regard to those of their pupils who hold scholarships or have part of the full fees remitted. The public schools are definitely an alternative to the State system of education, which those supporting them think superior to the State system, and which provide certain things—in particular, boarding-school life—which the State system does not try to provide. I am not concerned here with the question whether it is desirable that public schools should exist, I am merely arguing that, as long as a section of people consider this type of education superior to the State system, and the most desirable type for people of their class, so long will they endeavour to provide it for those children in their class who, through various accidents, cannot have it provided by their parents.

The provision of post-primary education by charity is often in the form of unorganized financial help to the children of relations or friends, but there are a good many charities (particularly endowed charities) which provide help with education or professional training for children resident in particular areas, or whose parents are members of certain occupations. It seems unlikely that even if the State were willing to give as much general education as they desire to all its members, it would be willing also to pay for all professional training, except in a fairly advanced stage of socialism, when training might be given for all forms of professional State employment in the same way as it is at present given for teaching. Unless we reach this state of affairs there will remain considerable scope for charity in the provision of professional training.

Another important form of supplementary charity is

the provision of pensions. Many benevolent institutions come under this heading, for example, the Governesses' Benevolent Institution, which provides annuities of £30 to £52 a year for governesses over 55 years of age. Many associations give help to the widows and orphans of members. Much of this type of charity would become unnecessary if the public system of pensions were on a more generous scale—as regards amount of pension, age of eligibility, and persons included in the scheme. But it seems likely that as the standard of general provision rises so will the standard considered suitable for members of the higher income groups, that is to say that the standard aimed at for the provision for distress among members of any group is set in relation to the standards of that group, not on any fixed basis. With regard to any pensions scheme financed from taxation, the State cannot recognize these differences of standard between different income groups. They can be recognized, however, in contributory insurance schemes, and, if these came to cover the whole of the field, and to cover all contingencies, this type of charity might become unnecessary.

Educational charities and benevolent institutions will suffice as examples of supplementary charities, though there are other types also. The social fact expressed by this type of charity is that many people feel stronger economic obligations to the fellow-members of a profession, a class, or a cultural group than they do towards the general body of their fellow-citizens, and are willing, as charitable donors, to supplement for their fellow-members of that group the provision which, as tax- and ratepayers, they make for all their fellow-citizens. Members of certain groups may also be given preferential treatment by charitable donors outside their group on the ground that they have a legitimate expectation of a higher standard of life than that of the majority of the population.

## 2 EXPERIMENTAL CHARITIES

The importance of philanthropy in the field of experiment is a point on which all students of the subject seem to agree. The State cannot act until the majority of the legislature are

convinced of the desirability of a measure. To this statement there is one important exception. In the spheres of activity in which local authorities have permissive powers it is possible for a local authority to act as soon as it has the support of the majority of citizens in its area. Thus many experiments are made in progressive areas and probably many more would be made if the law were changed so as to allow more freedom and initiative to local authorities. It is desirable that such a change in the law should be made, but even then no local authority could act until it had the support of the majority of local opinion and there would still be scope for the experimental work of voluntary organizations.

If we examine the range of the present public social services we find that it is the rule rather than the exception that the service was first provided by a voluntary agency. The reason for this is not hard to find. It is difficult to persuade either the elector or the legislator of the desirability of something new in the abstract, he likes to see the new idea embodied in actual examples before he commits himself. Sometimes, though the existence of a social need is obvious, the means to supply that need is not obvious. For example, the evil of a large infant mortality was obvious at the beginning of this century, what was not so obvious was the possibility of preventing a large proportion of this mortality and the importance of an advisory service for mothers as a means of prevention, so that the experimental work of voluntary infant welfare organizations was most important. Sometimes it is the need itself which is not obvious to the public, as with the large number of minor ailments among school children discovered by the first voluntarily provided school nurses. Sometimes it is the nature of the desirable which requires to be demonstrated, as with the model housing estates erected by voluntary bodies, which set a new standard for working-class housing.

The need for experiment in the social services is not a matter only of the past, and there are a number of experimental charities at work at present.

A good example is the Child Guidance movement, which, although its history in this country extends over only about ten years, has already established itself in some areas as part

of the public educational system. This movement is concerned with the diagnosis and correction of behaviour disorders in children. The first Child Guidance Clinic was the East London Clinic, started in 1926 by the Jewish Health Organization of Great Britain (but available for children of all denominations). In 1927 the Child Guidance Council was formed (financed largely by the American Commonwealth Fund), to promote the formation of clinics and to engage in educational and propaganda work. It started a second clinic in London two years later. Clinics were started not only in London but in several provincial towns, financed voluntarily, and often partly staffed by voluntary specialists. In some cases, however, public funds have recently become available. In 1932 the Board of Education allowed the Oxford City Council to spend £150 a year on an 'educational clinic,' and in 1935 it allowed the Birmingham City Council Education Committee to finance a Child Guidance Clinic, the expenditure to rank for grant as part of the provision for the school medical service. (The Birmingham Clinic had already been running for three years in connection with the special schools service of the Education Committee, but the cost had fallen wholly on private funds, which had been provided for an experimental period only.) Publicly financed clinics are now established also in several other places and the principle has been established that a Local Education Authority may contribute to voluntary child guidance clinics for services rendered to children referred by the school medical officer. The words of the Chief Medical Officer of the Board of Education in his Annual Report for 1934 are an interesting comment on the place of experimental philanthropy. 'It will therefore be noted that the Board's action in approving the establishment of a child guidance clinic as part of the school medical service in Birmingham is in line with the general principles of English educational administration—to wait until a new development has shown its worth under voluntary management, to note whether there is a widespread desire for extension of that development (as they have noted the work and comments of school medical officers in the past five years), and then to permit extensions by Local Authorities in suitable cases which are kept under review.' It may be noted that Child Guidance



Clinics have done important pioneer work not only in the sphere of the special services rendered but with regard to social case work in general. Their case work is among the most thorough done by any social agency, and they have developed a technique of team work between different kinds of specialists (in their case the psychiatrist, the psychologist, and the social worker) and of periodical case conferences for all those workers interested in a special case.

It is in experimental charities that the philanthropist is performing one of his most important functions, that of giving a fuller content to the idea of citizenship. New ideas and attitudes come first not to all but to a few, and the voluntary organization is the medium through which they are spread to the general public. In order to fulfil this function properly the voluntary organization must know not only when to start a venture but when to relinquish it to the public authority, and should be eager for this as the aim of its endeavour. When it has convinced the public of the utility of the service supplied it has done its job and should be glad to hand over financial responsibility, so that voluntary funds can be released for further experiments. This point needs emphasizing because a voluntary organization does not always find it easy to hand over responsibility when the experimental stage is passed, it fears the spoiling of its newly developed service by those inexperienced in it, and it itself has become a social group evoking affection and loyalty. But in many cases the service cannot be adequately provided except out of public funds, and it is a pity that voluntary funds, needed urgently for further experiment, should be absorbed in inadequate provision.

### 3. CONTROVERSIAL CHARITIES

#### (a) CONTROVERSIAL SOCIAL SERVICES

Except in the spheres of education and religious activities it is unusual to find a social service being provided about the value of which there is strong controversy. There is often controversy about how urgent it is to provide a certain service, and about the best methods of relieving certain kinds of distress, but there is not often so much division of opinion

that a service which some people consider desirable others consider a positive evil. This, however, is the case at present with regard to the dissemination of information about methods of contraception, and the birth control movement provides a good example of a social service which is provided by voluntary, not public, bodies because there is controversy about the desirability of the service being provided at all.

The first birth control clinic was established at Holloway in 1921, the second at Walworth in the same year, and the third at North Kensington in 1924. The first clinic outside London was established at Wolverhampton in 1925, followed by Cambridge in the same year. In February 1936 there were 48 voluntary clinics in Great Britain. These clinics are financed mainly by the fees paid by patients and by the charitable donations of local supporters, and they are usually conducted as separate associations. There are two national organizations for the promotion of birth control—the Society for the Provision of Birth Control Clinics, founded in 1922, and the National Birth Control Association, founded in 1930.

In the early years of the movement there was no assistance from public authorities, but in 1930 several local authorities consulted the Ministry of Health as to the possibility of providing advice on birth control, and the Government authorized a statement of official policy, which was circulated to all local authorities in the following year. The principles of the memorandum and circular of 1931, which principles still obtain, are that local authorities may give advice and instruction on methods of contraception either to expectant and nursing mothers attending at maternity and child welfare centres, or at gynaecological clinics under the Public Health Acts, in those cases only where further pregnancy would be detrimental to the health of the mother. 'What is, or is not, medically detrimental to health must be decided by the professional judgment of the registered medical practitioner in charge of the clinic.' A further circular in 1934 definitely recommended that advice should be made available in certain cases of organic disease where childbearing would be likely seriously to endanger life. Local authorities may also contract

with voluntary clinics to give advice to women referred to them on grounds of health. In February 1936, 60 local authorities had established clinics and about 100 others had taken some steps to make advice available, while over 250 had done nothing in the matter.

The present position is a compromise—local authorities are permitted to give advice in certain cases where there are special medical circumstances, they are not allowed to give advice in other cases. The compromise is due partly to the fact that the service is still regarded officially as being in an experimental stage, but it is due more to the fact that many people object on principle to the use of any artificial methods of contraception. The most important organized opposition to birth control is that carried on by the Roman Catholic Church. There is also an undenominational organization, the League of National Life, which exists to oppose it.

The controversy over birth control is a very interesting example of the general problem as to how far the State is justified in overriding the strong convictions of a minority. For it may be argued on the one hand that it would be unjust to make Catholics and others who object to birth control pay rates and taxes to help further it, and it may be argued on the other hand that they are at present forcing their views on many who disagree with them, because the supply of voluntary clinics is not at all adequate to meet the demand for advice. The fact that there is a substantial minority opposed to a certain service does not seem to me to be an adequate reason why it should not be financed by the State, and there are several cases at present where it is so financed. Opponents of vaccination may claim exemption from the operation but they are compelled to assist in paying for the services of the vaccination officers. Nonconformists and atheists must help to finance Catholic and Anglican elementary schools, and pacifists must help to finance the armed forces. On the other hand the existence of an opposition of this nature to any particular social activity is, in my opinion, *some* argument against the organization of that activity by the State, as the successful working of a democratic system depends upon respect for the opinions of minorities as well as upon a sensitive response to the wishes of the majority.

(b) THE ACTIVITIES OF RELIGIOUS ORGANIZATIONS

The trend of modern opinion in this country has been in favour of the dissociation of the State from purely religious activities. The State in Britain does not, in general, organize nor finance purely religious activities but leaves such activities to the free control of voluntary organizations. The exception to this statement is the association of the State with the Anglican Church as the 'Established Church' in England though the Anglican Church receives no revenue from taxes or rates it has a considerable revenue from compulsory tithes, and it is not completely free to control its own activities as it wishes. In Scotland the State is associated with the Church of Scotland as the 'Established Church'.

I am in favour of the complete dissociation of the State from purely religious activities for two reasons. One reason is that, at the present time only a minority of the population are members of any one religious denomination (if we exclude the large number of merely nominal members of the Anglican Church). State aid to any one denomination is therefore likely to be resented by citizens who are members of other denominations or of none. The second reason is that religious activities are essentially unsuitable for State organization or supervision in that they are of value only when completely voluntary, and in that they imply appeal to a wider law and loyalty to a wider community than that of the State. Thus the association of the State with religious activities is likely to be unfair to the general body of citizens and cramping to the activities of religious believers. It is unnecessary to enlarge on these arguments as there is no movement in this country at the present time to associate the State further with purely religious activities. The controversial questions of policy arise with regard to the activities of religious bodies in education and in social work.

It is in the sphere of education that there has been and remains the greatest controversy as to the relation between the State and religious bodies. Before the State assumed responsibility for elementary education it was provided largely by religious organizations, and the public educational system has always included both undenominational and

denominational schools In 1934, out of 20,842 public elementary schools in England and Wales, 10,014 (with 3,860,000 children) were 'provided schools,' entirely under the control of the local authority, and the other 10,828 (with 1,790,000 children) were 'non-provided schools,' partially under voluntary control Of these non-provided schools 9,268 were Church of England and 1,215 were Roman Catholic schools There were a much smaller number of Methodist, Jewish, and other non-provided schools The general position is that the non-provided schools are financed publicly with regard to the salaries of the teachers and the general running expenses of the school, but that the voluntary body responsible must provide and maintain the school buildings In return for this expenditure the voluntary body appoints the majority of the school managers, gives its own form of religious instruction in the school, and discriminates in favour of teachers who are members of its denomination (This position has been somewhat modified by the Education Act of 1936)

There are considerable disadvantages in this system from the point of view of adequate educational provision The religious bodies concerned have often found it very difficult to raise the funds necessary to keep up and extend their buildings in accordance with modern educational requirements The existence in many areas of three types of schools has made the regrouping of children under the 'Hadow Scheme' more complicated than would have been the case had only one type of school existed In some areas the denominational school is the only school within easy reach

The controversy arises because of the existence of two principles of which the relative importance is differently stressed by the contending parties. On the one hand the State insists that all children of all denominations shall be provided with education of at least a certain standard, and this standard includes adequate and suitable buildings On the other hand the Anglican and Roman Catholic Churches argue that the children of their members should receive their own form of religious instruction, and that they should be educated by teachers of their own faith These churches cannot finance education for all their members without State

assistance, and the present system is an effort to satisfy the requirements of both these principles

The many activities of religious bodies in the provision of other types of social services have not provoked controversy to the same extent as their provision of education. These activities are very varied and so are the reasons for undertaking them. Some of the social and relief work of churches is confined to their own members and is thus a form of supplementary charity, in the sense in which the term was used earlier in this chapter. Much social and relief work for the general population is undertaken by churches because there is an urgent need for it which is not being adequately met by other existing efforts. In some of this work there is no essential reason why the work should be undertaken by a religious rather than a secular voluntary organization, but the church members whose sympathies are aroused find it more convenient to carry on the work as part of the activities of their church rather than to found a separate organization for the purpose. Examples of this type of work are much of the general relief work of London missions and the provision of allotments for the unemployed by a committee of the Society of Friends. The case for and against such types of work being engaged in by voluntary organizations rather than by the State is not radically influenced by the fact that the voluntary organizations concerned are religious bodies.

There are, however, some types of social service which are provided by religious bodies either because they are regarded as a desirable supplement to the religious activities of these bodies or because it is thought that such types of work are better carried on from a definitely religious standpoint. Examples of this type of service are the work of the Salvation Army for 'down and outs,' the 'rescue work' of Anglican Diocesan Societies, the work of police court missions, the work of Homes for children under religious bodies. In the last example it may be argued that the religious influence of the Home is often of the same character as that which the child would have received from its parents (at any rate nominally), so that the Home is merely acting *in loco parentis* in this as in other respects. With regard to the other three examples, all these types of work necessitate a belief in the possibility of

altering the lives of individuals who, for the time being at least, are personal failures. Such a belief, both in the social worker and in the individual assisted, is likely to be fostered by religious conviction, and therefore religious organizations may be particularly successful in this type of work. But it is important to remember that faith in the redeemability of individuals is not confined to members of one denomination nor to religious believers. The organization of any types of social work mainly by religious organizations, particularly if such organizations are denominational, is likely to exclude many potential workers in those fields.

The fact that some social services are provided by religious rather than secular voluntary organizations has not prevented the giving of grants by public authorities in appropriate cases. For example, grants are given to maternity homes for unmarried mothers, to cases in children's Homes, and to the probation work of police court missions.

#### (c) PROPAGANDA

Many propaganda societies are not regarded as charities by the law, nor are many of them regarded as charities in the ordinary use of the term. I consider, however, that voluntary financial contributions and voluntary personal service to propaganda activities should be regarded as types of philanthropy. They come within the definitions of 'charity' and 'voluntary social service' stated in the Introduction to this book, because they are given to purposes of no direct economic benefit to the donor: they are concerned with the welfare of others or of the whole community. Another reason for including propaganda activities within the scope of philanthropy is that many associations combine propaganda with other activities which are charitable in the ordinary sense.

Propaganda activities are not necessarily unsuitable for organization or support by the State. It may be that the objects of the propaganda are accepted by the majority of the legislature or local authority and that they wish to convert the whole body of citizens. Public authorities may themselves organize this propaganda—two examples are recruiting propaganda for the military forces and the campaigns of the Ministry of Health and local authorities to induce greater

use by the population of the public health services. Public authorities may subsidize the propaganda work of voluntary organizations—an example is the public grants to the British Social Hygiene Council. The object of this Council is propaganda work to combat venereal diseases, and in the year 1934-35 it received grants from at least 75 local authorities in England and Wales to a total of at least £2,600. While there is general agreement about the importance of combating venereal diseases there is considerable disagreement as to the best methods of achieving this object. The Ministry of Health has taken sides in the matter in favour of the views of the British Social Hygiene Council, which combines its health propaganda with propaganda in support of the Christian standard of sexual morality, as against the views of the National Society for the Prevention of Venereal Disease, which advocates dissemination of knowledge as to methods of self-disinfection.

But public authorities can engage in propaganda only when the objects of such propaganda are approved by the majority of citizens. In this country much more pure propaganda is carried on by voluntary organizations than by public authorities. (I say 'pure' propaganda because there is an element of propaganda in many social services and educational activities.)

There is little doubt that, if religious organizations are excluded, political parties are the propaganda organizations of the greatest financial importance. But in general, and even with regard to political parties, the amount of work done by a propaganda society cannot be calculated from the amount of its expenditure, as voluntary personal service is very important. Though paid organizers and speakers are often employed, a propaganda society aims at making all its members take an active part in its work, and, though this is seldom completely attained, there is a very large amount of voluntary work done by members. Much of this work is of a kind which cannot be classified or computed but, as an example of work done for a definite object, we may instance the half-million and more of voluntary workers who assisted in taking the 'Peace Ballot' of 1934-35.

Propaganda societies are usually working for one or both



of two objects—the conversion of individuals to their views and changes in the law. There is much scope for the work of societies whose objects are particular changes in the law. This is especially the case when the changes advocated are not part of the programme of any of the political parties. In such a case the scarcity of time in Parliament means that measures are not likely to be considered unless those citizens interested in them organize to put pressure on the Government and M.P.s. A society whose object is a particular change in the law may, of course, completely attain that object, and become unnecessary unless there remain allied objects to be furthered. For example, the Women's Suffrage Societies in 1928 completely attained their primary object of an equal franchise for the two sexes, but they have continued (under other names) to work for other kinds of sexual equality. Where, however, the work of a society is concerned with influencing types of individual action not amenable to legal control, the necessity for its work is not likely to cease, as there will always be a new generation to be influenced. But its work may become easier if it has managed to alter the social tradition on the matter in question.

Our view of the social function and importance of propaganda societies is apt to be determined by whether we agree with the objects of particular types of propaganda. In the case of some propaganda there is no serious opposing view to be combated but merely indifference and inertia. Other propaganda represents one side of a controversy. Some divergencies of view have a possible reconciliation but this is not true of such opposites as the views of the British Women's Total Abstinence Union and the Fellowship of Freedom and Reform on the subject of teetotalism, the Peace Pledge Union and the Navy League on the subject of war, the Independent Labour Party and the British Union of Fascists on the subject of socialism, the Catholic Truth Society and the Rationalist Press Association on the subject of revealed religion. In such cases we are tempted to think that if the views of one side are right the work of the other side must be regarded as destructive, or at least as effort entirely wasted.

But I believe that this conclusion is not the whole truth

and that there are at least two arguments in support of the value of the work of propaganda societies, even when the objects of such societies are diametrically opposed. Firstly, whether or not the optimistic view is justified that ultimately the right will prevail, there is no other way of arriving at the right than the way of experiment and controversy. Secondly, free and active controversial propaganda is indispensable to the effective working of democracy. The basis of democracy is belief in the ultimate authority of the individual judgment and the same belief is the basis of the toleration and appreciation of controversy. The totalitarian State does not hold this belief and has no use for either the individual judgment or any propaganda but its own. The democratic State aims at developing a body of citizens willing to think and act for themselves, not a body of disciplined subjects. It assesses the wastes and mistakes involved in the exercise of free individual judgment as lesser evils than the atrophy of conscience and intelligence involved in enforced uniformity.

#### 4 INTERNATIONAL CHARITIES

The three spheres of philanthropy which have been discussed so far in this chapter are cases in which the limitations of the State arise from the fact that the State gives its attention to the needs and opinions of the majority. It cannot, on this basis, supply certain groups of citizens with social services at above the universal level—thus there is a sphere for philanthropy in providing supplementary services. It cannot act until the majority of citizens (or, in practice, the majority of their representatives) think that the value of and need for any special social service is evident—thus there is a sphere for philanthropy in the field of experiment. It cannot act where the subject of action is controversial and there is no clear majority opinion, nor can it usually act in propaganda for changes in the law—thus there is a sphere for philanthropy in controversial action and propaganda. There is also a most important sphere for philanthropy in international charities. I include in this category not only philanthropy organized by international societies but all charity and voluntary social service given by nationals of one

State to nationals of another. The limitation of the State which gives international charities their sphere' and importance is its limitation of geographical scope and all the conditions resulting from this. A World State would be free from this limitation, but the possibility of a World State seems, as yet, to be very remote, and under present conditions we have to consider not 'the State' but many States, with relations between them varying from a considerable degree of co-operation to a state of war. This division of the world into many exclusive States does not correspond with the facts of economic and cultural relations, nor does it correspond with many people's sense of community. Outside the family the national community is possibly the most important community for most purposes for most people, but this is not true for every one, and even for those for whom it is true there are some purposes for which other kinds of community are more important. This is not realized in our political organization, which labels people tidily as nationals of a certain State and local electors of a certain borough or county, and tends to regard those relationships as suitable and sufficient to satisfy their social feelings and public spirit.

An example from my personal acquaintance will amply demonstrate that this neat classification does not always fit the facts. The individual who serves for this example has given a large part of her energies for most of her life to befriending the victims of war and revolution. She worked for several years in the War and post-War period in administering relief in various countries, including both States which were the allies of Britain and States which were her enemies. Since then she has continuously entertained and otherwise befriended a succession of refugees ranging from White Russians to German Socialists. She is a notably generous and public-spirited person. But she has little interest in her country's domestic politics and almost no interest in local government—she knows far more about the government of Vienna than about that of the city in which she lives. Thus she might well be the despair of the public administrator and still more of the political propagandist.

The individual in my example has carried on much of her activity independent of any organization, and about such

activity, in this as in other spheres of philanthropy, it is impossible to get collected information. We must be content with a consideration of some of the organized forms of international philanthropy. As might be expected there is as much variety in the services which the charitable wish to provide for those in need in other countries, as for those in need in their own country, so that this classification cuts across the other classifications discussed above. The best division of international charities seems to be between those dealing with needs arising under ordinary peace-time conditions and those dealing with needs arising from war, revolution, and persecution of minorities.

The scope for the first type of international charity lies in the fact that communities in different countries differ very much in their economic resources and that Governments differ very much in their efficiency of organization in relation to the relief of distress. For example, many countries have very low standards of health services in comparison with those prevailing in Western Europe and lack not only the material resources but also the knowledge necessary to raise them. The work of missionary societies, though not undertaken primarily with the object of relieving and preventing illness, has been very important in this sphere, and it has also been important in providing education in many places where there are few educational facilities existing. Several of the English missionary societies were founded in the eighteenth century (particularly at the end of it) and are thus much older than other forms of international charity, which, on the whole, are a modern development. The fact that the main work of foreign missions is of a controversial nature has probably meant that their importance as agents of civilization and promoters of friendly contacts between members of different nations and races has been underestimated. As against the narrowness of theological views and the self-righteous attitude of superiority which have sometimes prevailed must be set the refusal of the missionary to recognize other than religious divisions—every one of whatever race, nationality, sex or class has a right to participate in the true religion (whatever the true religion may be held to be). In a world divided by racial, national, and class animosities

this attitude is very valuable. Another contribution of the missionaries has been that they have gone to live in the foreign countries concerned with the main object of helping their inhabitants, and they have thus provided an alternative example of European civilization to that provided by the soldier, the trader, or the government official, whose objects have been more mixed.

Apart from the work of missionary societies there have been organized relief funds for conditions of exceptional distress, such as the results of famines and earthquakes, and a good deal of philanthropic work under peace-time conditions is done by such bodies as the International Red Cross and the Save the Children Fund, both concerned originally with needs arising from war. The work of international federations of trade unions, professional bodies, and propagandist organizations also includes philanthropic activities. The founding of the League of Nations and the International Labour Organization has given a great stimulus to international organization of voluntary societies concerned with various aspects of their work.

In their peace-time activities international charities act mainly in supplementing the social services provided by States. In their war-time activities their special character is much more distinct, for here they are engaged in alleviating conditions caused by the misdeeds of States. When States become the destroyers and oppressors instead of the servants and protectors of ordinary people the work of relief must often be carried out by philanthropy if it is to be carried out at all.

International war charities fall into various groups according to the cause of distress and of the failure of the State to relieve it. (I am not including here the many forms of war charities which help the compatriots of the donors, as these are not illustrations of the principles discussed in these paragraphs.)

Much international charity in war time is necessitated by the fact that some of the countries at war are so disorganized or so impoverished by the war as to be completely unable to meet the most essential needs of their citizens. The position of Belgium and of Serbia during the Great War are striking

examples of this state of affairs in both these cases much help was given by the philanthropic activities of members of allied States less disorganized and impoverished, for example, Great Britain, or of neutral States, for example, the United States. A recent example is the work of the International Red Cross and of the Red Cross Societies of several countries on behalf of the Abyssinians, who were entirely unable to provide the necessary medical services for either their soldiers or civilians. Other examples are the present work of philanthropic societies in Spain and in China. A special form of relief which is often necessary is provision for refugees fleeing from invading armies and entirely cut off, for the time being, from any possibility of help from their own governments.

War relief includes not only work during the actual period of the war but work to alleviate its results in the post-war period. The end of the Great War left many populations on the verge of starvation and many areas desolated. Philanthropic societies were much more alive to these needs than governments and much more willing to relieve distress in ex-enemy as well as ex-allied countries as soon as this became possible. The work of such bodies as the Save the Children Fund and the Friends War Victims Relief Committee was of great importance in Austria, Germany, Poland and Russia, not only in furnishing immediate relief but in re-starting normal economic life. In some cases there was some backing from governments, for example, at one period various relief societies were receiving from the British Government a pound for pound grant in aid of their work. Efforts towards the reconstruction of economic life and towards the repatriation of refugees were also helped by committees of the League of Nations.

Another type of relief work necessitated by the Great War was the relief of 'enemy aliens' stranded in countries with which their governments were at war. These people were cut off from any possibility of help from their own governments and were in the midst of a predominantly hostile population, which often deprived them of any means of making a living even when, as in the case of the women, they were left at liberty. The Friends Emergency Committee

for the Assistance of Germans, Austrians and Hungarians in Distress worked in Great Britain all through the War period in assisting the families of enemy aliens and in doing such social and educational work as was allowed among the civilians in internment camps and among prisoners of war. A society with similar objects was at work in Germany on behalf of British and other enemy aliens stranded there.

Revolution and dictatorship have, in recent years, raised problems of relief similar to those raised by war, the difference being that in this case those relieved are in need of help because of the misdeeds of their own governments, not because of the misdeeds of the governments of other States. The unfortunate nationals of any State who are deprived by their governments of their rights as citizens have, in the existing state of international law, no legal claim on any one. The plight of the White Russian refugees from the Soviet Government and of the German Jewish and Socialist refugees from the Nazi Government are but the most striking examples of a condition of affairs which has existed to some extent with regard to many countries. With regard to the German refugees a great deal of help has been given by philanthropic organizations and seems likely to continue to be given.

This brief account of the different spheres of work of international charities is quite sufficient to demonstrate that there is ample room for philanthropy rendered by nationals of one State to nationals of another, and that, unfortunately, the need for such philanthropy will probably long continue. The greatest defect in the State as we know it to-day is that it is not the organ of a world community or even part of a co-ordinated system of governments covering particular areas, but an entity which considers itself to be sole judge of its own actions and independent of any obligations to those outside its borders. This state of affairs has not only the negative result that it prevents an organization of political life in adequate response to the needs of world economic life, but also the positive result that the State in its external relations acts very differently from in its internal relations, and more often to destroy than to increase social welfare. We have the germs of a better state of affairs in the rules of international law, in the League of Nations and the

International Labour Organization, and in many economic, cultural, social, and religious organizations which extend across national boundaries. The importance of international charities lies not only in their immediate success in relieving distress but in the fact that they are one of the germs of a possible future international community. The work of the British relief societies in Germany and Austria in the post-War period was not only saving life and health but was helping to soften the bitterness of defeat and to reconcile former enemies. The recent work of the Red Cross Societies in Abyssinia, hopelessly inadequate as it was, has given to the Abyssinians an alternative view of European civilization to that presented by the bombs and poison gas of the invader. The missionary societies have worked in the name of an ideal and a community which they claim to be potentially world wide. Whatever may have been its defects, the work of philanthropic organizations in the international sphere has been a much greater contribution to social welfare and civilization than have most of the actions of States.



## CHAPTER III

### THE PLACE OF VOLUNTARY PERSONAL SERVICE

#### INTRODUCTION

THE last chapter described the spheres in which there is need or justification for the voluntary charitable organization because, for various reasons, the action of the State is limited in those spheres. This chapter is concerned not with charity but with voluntary personal service—with the place of the voluntary social worker and the voluntary administrator in both the public and the voluntary social services. The chapter is divided into three sections. The first discusses the scope for 'voluntary social work' in the sense of voluntary part-time work in the actual rendering of some social service. The second section discusses the scope for the voluntary administrator—the member of a committee administering a public or voluntary social service. The third section urges the importance of participation by the ordinary citizen in either or both of these activities as a training in citizenship.

The peculiar features of voluntary work arise not from the fact that it is unpaid but from the fact that it is a spare-time activity, bringing the ordinary citizen into contact with social work and social administration. Thus the rare cases in which individuals engage in full-time social work or full-time administration without receiving payment for their work are not examples of the types of work discussed in this chapter.

#### THE SCOPE FOR THE VOLUNTARY SOCIAL WORKER

The division between voluntary and professional social work cuts right across the division between public and voluntary social services. Voluntary charitable organizations employ professional social workers as well as using the

services of the voluntary amateur, public authorities enlist voluntary help to supplement the work of their professional employees. The pros and cons regarding the use of voluntary workers in any particular branch of social service are not affected essentially by whether that service is administered by a public authority or by a voluntary organization. In practice, however, the voluntary organization is likely to make more use of the voluntary worker than the public authority. The voluntary organization tends to be understaffed owing to shortage of funds and to welcome the apparent economy of using unpaid workers. The public authority is not so likely to have this motive and finds it difficult to make the voluntary worker fit into its more methodically regulated system.

A good many recent developments in social work have tended to replace the amateur by the professional. As particular branches of work have developed the number of cases dealt with has become so large as to make the employment of full-time workers essential. Increasing use has been made of specialist knowledge, to obtain which the worker needs full-time experience of the work and often professional training. An increasing realization of the interdependence of social problems and the increase in the range of the social services themselves has made it desirable for many workers to have a greater general knowledge of social conditions and problems than is usually possessed by the amateur. For these and other reasons the main work of many philanthropic organizations is now carried on by professional workers. With the problems of the training and employment of professional social workers this book is not concerned. The activities of voluntary social workers, however, fall within its scope as being a very important form of philanthropy, and it is interesting to enquire what place there is for them under present conditions.

• (a) THE VOLUNTARY WORKER AS FRIENDLY VISITOR

One great advantage of the voluntary over the professional social worker is that, as he is dealing with relatively few cases, he can take a greater personal interest in each individual case. He is of particular value in circumstances where what

is needed by individuals is not so much financial help or specialized advice as some one who will take a continuous friendly interest in them. There are large numbers of such cases and a few examples will show the variety of the need. There are, for instance, the old people in poor law institutions who have no relations or friends to visit them. Their need is simply some one who will break the monotony of their lives by coming in from the outside world and bringing them news of it and who will give and receive affection. There is a similar need for friendly visiting in the case of many old age pensioners, particularly those who are living alone. For example, Sir H. Llewellyn Smith, in the report on 'Old Age and Poverty' in The New Survey of London Life and Labour, Volume III, speaks of 'the great field which lies open to voluntary and sympathetic assistance, not in the way of financial help, but of friendly visits to the old. It has been an extraordinary experience to find how pathetically glad most of these old people were to receive visits of the Survey representative and to pour out their stories in her ears'. The Liverpool Personal Service Society started in 1927 an Old People's Welfare Department, which, in its first year of work, tried to 'cheer the lives of some 800 men and women over the age of 65 living alone or perhaps in unsympathetic surroundings'. It arranged monthly social afternoons in various parts of the city and motor drives in the summer besides visiting the old people in their homes. It also arranged to visit some of the bed-ridden people in the aged and infirm wards of one of the poor law hospitals.

Lonely old people are possibly the most striking example of cases where the main need is simply friendly interest, but there are many other examples, for instance, invalids of any age confined to the house as well as many in hospital, children and young people deprived of normal home life, discharged prisoners and other offenders against the law who need encouragement to recover their self-respect and the respect of their neighbours. Many of the people supplying these types of needs are doing it spontaneously and without the necessity of any organization, and they would probably be most surprised to be told that they were engaged in 'voluntary social work.' But there must be also many cases where the

need is not even discovered until some organization has endeavoured to meet it. An example of such an organization is the Manchester Voluntary Unofficial Aunts which, among other activities, provides volunteers to read to blind people, stay for an evening with invalids and the friendless, and lend cars to take people to and from hospital. It is my impression that a great deal more of this kind of service could well be given. This impression is strengthened by the evidence of many cases dealt with by philanthropic organizations where the organization would be only too glad to put the people concerned in touch with a friendly visitor when the particular emergency with which it has been dealing is over.

(b) THE VOLUNTARY WORKER AS LIAISON OFFICER

Another sphere for the voluntary social worker is to act as a kind of 'liaison officer' between those administering social services, whether public or voluntary, and the general public. Both the general legal system and the system of social services are extremely complicated, they are often perplexing even to well-educated people and they must be a complete puzzle to many of the individuals whom they are intended to benefit. There may also be ignorance of simple rules of health and of medical terms so that full advantage is not taken of the medical advice given by doctors in, for example, the out-patient departments of hospitals. A good deal of the work of Poor Man's Lawyers, Councils of Social Service (by whatever name they may be called in different places), Housing Advisory Bureaux, school care committees and many other organizations is concerned with giving their clients information and advice or interpreting for them unintelligible information or advice which they have already received. Some of this work is best done by full-time professional workers, whether employed by public authorities or by voluntary organizations, but its usefulness can often be greatly increased by a system of voluntary workers under the direction of a professional worker. One of the best examples of this is the London Care Committee system, which is illuminatingly described by Miss Hilda Jennings in her book 'The Private Citizen in Public Social Work'. The London Care Committees are concerned with all the work with regard

to child welfare which has developed in connection with the school medical service and the provision of school meals and in general with making all the existing public and voluntary social services available in the service of any school child in need of them. The Care Committees are responsible to the Special Services Sub-Committee of the London County Council Education Committee. A committee exists for each elementary school and consists partly of representatives of the school managers and mainly of voluntary workers appointed by the Special Services Sub-Committee. There are local Associations of Care Committees in each Borough and full-time professional organizers for each of the twelve divisions into which the area is divided for this purpose. There were in 1927 922 care committees with about 5,100 members. Miss Jennings, in her summary of the significance of the system, gives two main reasons for desiring the continuance of the voluntary social worker. 'In the first place, such work brings the individual volunteer into more intimate touch with his fellow-citizens than does purely political effort directed towards governmental activity, secondly, a wholly bureaucratic public social service involves the presentation of public social benefits with authority and an element of compulsion, whereas the use of the volunteer as the agent of society makes it possible to avoid any suggestion of external force, and to appeal for the free co-operation of the persons whose social capacity it is desired to promote.' The latter point emphasizes the fact that one of the objects of the advisory and interpretative activities of social workers is to secure intelligent co-operation with the law instead of hostile or indifferent acquiescence. The attitude of the person concerned can often be changed when he is helped to understand the general purpose and effects of the law in question instead of being aware only of its anomalies and irksome requirements. The fact that the voluntary worker is an ordinary person with no special axe to grind in the matter often gives him an advantage in winning the confidence of the client in this kind of interpretative work.

The other aspect of the activities of the voluntary social worker as a liaison officer is that he can communicate and interpret the needs and wishes of his clients to the agencies

concerned. He has more time than has the professional worker to spend in getting to know his clients, he can engage more freely in those apparently irrelevant conversations which may, in the end, be more illuminating than formal enquiries. He is not in danger of developing a professional outlook and can thus often more easily understand how the facts strike the 'man in the street'. This aspect of his work may be extremely important. Even where the public services are concerned the ordinary machinery of democratic representation is quite inadequate to enable the average elector to get across to the officials concerned his view of the working of a particular social service as it affects him, and the social worker, whether professional or voluntary, may be a most useful intermediary in the matter. Many beneficial legislative and administrative changes have been the result of the evidence of social workers (using the term here in a very wide sense) as to the anomalies, gaps, and injustices of the law as they have learned of them from their clients.

(c) THE VOLUNTARY WORKER IN EDUCATIONAL AND  
RECREATIONAL ACTIVITIES

A third important sphere for the voluntary social worker is in many kinds of educational and recreational activities. Clubs, Scouts, Guides, Sunday Schools, and other organizations for juveniles, settlements, community centres, women's institutes, mothers' meetings, Co-operative Guilds, Adult Schools; these are but some examples of the many social, recreational, and educational organizations where much of the work of organization and leadership is done by voluntary workers. In this group of activities the voluntary worker is essentially joining in a group purpose and sharing his ordinary interests with his fellow-members. There is very little distinction between giver and receiver—in the adult organizations the rôles often pass from person to person according to the nature of the service required at any particular time. The professional worker has his place in such organizations, sometimes as an organizer, sometimes as a teacher of special subjects, but for the most part the organizations require regular but not full-time services and the kind of leadership or proficiency in sports or hobbies which many people possess and enjoy.

exercising There is room for much more development of this type of organization The need for provision of organized leisure-time activities for juveniles is becoming increasingly realized, and there is still a great deal of scope for the further provision of organized social, educational and recreational activities for married women Voluntary leaders and organizers are the essential elements in most of these types of organizations finance is of subsidiary importance

### THE SCOPE FOR THE VOLUNTARY ADMINISTRATOR

The scope for the voluntary worker in connection with social services is not limited to the cases where he can participate in the actual service rendered Even when the service itself is performed entirely by professional specialists the general administration and control is in the hands of voluntary committee members This applies not only to the services administered by charitable organizations but also to those administered by local authorities In Great Britain a great deal of use is made by the community of the voluntary administrative services of its members not only in voluntary organizations but in local government, in the administration of justice, and on governmental committees of enquiry into matters of public concern In general this wide use of the voluntary administrator seems to me to be admirable and I should like to see it extended to include the services of many more people

An objection is often felt to superseding voluntary organizations by public authorities in the provision of various social services on the ground that the community would lose the services of many of those at present administering these organizations, who are both interested and experienced in the department of work in question If the social service at present administered by a charitable organization were handed over to the public authority without the creation of any special administrative machinery this would certainly happen An example from the organization of district nursing will illustrate the point It will be shown in Chapter XIII, Section III (page 229) that about 280-290 persons, of whom about 230 were women, were engaged in 1934 as committee

members in administering district nursing in Birmingham. If the service were to become administered by the public authority it would presumably be administered, in Birmingham, by the Public Health and Maternity and Child Welfare Committee of the City Council. This committee, in the same year, consisted of 17 members, of whom 4 were women. It had no co-opted members. Now, on the principles laid down in Chapter I, district nursing is a service which should be publicly financed. But many of those at present administering it throughout the country have more interest in it and more ability to administer it than have the members of the Public Health Committees of the local authorities. A similar state of affairs exists with regard to various other social services at present administered by voluntary organizations, these organizations have enlisted and trained honorary officers and committee members who have a great interest in the particular service, and a specialized capacity developed by their experience in administering it. It seems to me very desirable that the assumption by the public authority of financial responsibility for a social service at present financed by charity should not involve the loss of the services of all those at present administering it.

This statement involves the view that local authorities should include in their administrative system the services of many more committee members than are included at present. The case for this view rests on several arguments. One argument is that participation in administration gives a very valuable training in citizenship to the individuals participating. This argument is developed below in the next section of this chapter.

A second argument is that it is necessary to extend the public administrative personnel in order not to lose the services of many capable women administrators. Although women are now equally eligible with men for election on local government bodies, they are still at a disadvantage in securing election, at any rate in many places, whereas they often have both more knowledge of the kind of problems involved in the administration of social services and more time to devote to the work. The desirability of making special provisions to secure the services of women committee members was realized



by Parliament in the legislation constituting the Education Committees, Maternity and Child Welfare Committees and Public Assistance Committees of local authorities. In most other cases no special provision has been made. It is possible, for example, for the Housing Committee of a local authority to consist entirely of men, and the same is true of the Public Health Committee in cases where it does not act also as the Maternity and Child Welfare Committee.

A third argument is that the number of people who can be elected as members of local government bodies is necessarily limited by the fact that a council or committee which is larger than a certain size cannot function effectively as a deliberative body. With the growth of large cities and the development of services which are most efficiently organized by taking large areas as units of administration the proportion of the population who can serve as local councillors decreases. (For example, in Birmingham in 1935 there were 136 members of the City Council and about 483,000 local government electors—1 member to every 3,550 electors. In Banbury there were 24 members of the Borough Council and about 7,400 electors—1 member to every 309 electors.) The reverse side of this limitation of the number of council members in the larger authorities is that those who do serve have to undertake so much work that the office becomes more a part-time job than a spare-time activity. This situation may have advantages but, under present conditions, it considerably limits the range of choice of candidates for election. It is impossible for the average employee to fulfil his duties as a councillor in his out-of-work hours and therefore he can act as a councillor only with the active co-operation of his employer and fellow-employees and at pecuniary sacrifice. This condition excludes many otherwise suitable candidates. The position is likely to become even more difficult as the public social services develop further and the duties of local authorities become wider. One possible solution is the payment of councillors in the same way that members of Parliament are paid, regarding local government administration as a full-time job. This may become necessary in some cases but it would be very regrettable if the part-time councillor were abolished. The person engaged in an ordinary

occupation is more likely to keep in touch with the "general public and represent its opinion than the full-time professional councillor, and unless the councillor does represent this ordinary unspecialized opinion he might almost as well abdicate and leave local government administration entirely to the permanent officials (There is in this argument no objection to the payment of councillors for the time spent in their public duties)

A fourth argument in favour of increasing the number of people engaged as voluntary committee members in public administration is that the present system limits the administrative personnel qualitatively as well as quantitatively. For one thing a good many public-spirited people have specialized public interests and specialized experience—they would willingly serve as administrators of, for example, hospitals or housing, without necessarily also being willing to administer the other local government services with which they would have to deal as councillors. Under present conditions we expect our councillors to have knowledge of and interest in a very large range of public services, while making very little use of the great variety of specialist interests and knowledge available among other citizens. So far voluntary organizations have been much more successful than public authorities in using the particular capacities and interests which individual citizens have to offer. Another drawback to the present system is that many public-spirited people do not take kindly to either electioneering or party politics, and that even when this difficulty is overcome the best administrators are not necessarily the best candidates.

For the reasons given above it is desirable that local government by elected unspecialized councillors should be supplemented by the inclusion of many more citizens as administrators of particular services. Local authorities have legal powers to co-opt outside members on to most, though not all, of their committees. (These powers are given either by Section 85 of the Local Government Act, 1933, or by Acts dealing with special services administered by local authorities.) In the case of some committees, of which Education Committees are the most important, it is obligatory to co-opt some members. In most cases it is laid down that a majority

—usually at least two-thirds—of the committee must consist of members of the local authority. Many committees have power to co-opt on to their sub-committees persons who are not members of the full committee nor of local authorities: in some cases it is laid down that the number of such co-opted members shall not exceed a certain proportion of the total number of members of the sub-committee. (In the case of Guardians Committees in county areas co-optation is obligatory.) Many local authorities do not make use of their optional powers of co-optation with regard to some committees, and much could be done within the existing law to include the services of more administrators. But it may be desirable in certain cases that the law should be altered to allow the co-optation of a larger number of outside members on sub-committees, and to allow the delegation of some matters of detailed administration to special sub-committees whose members are appointed by the full committee but are not necessarily most of them members of it. This would be particularly desirable if local authorities were to assume financial responsibility for social services at present administered by voluntary organizations. Some members of such sub-committees might well be nominated by groups with special interests, for example, parents' and teachers' associations in the case of education services and medical bodies and provident contributory associations in the case of health services, though of course such nominations would be approved by the full committee. (This principle is already adopted in some cases, for example, in the constitution of Education Committees.) In any schemes of co-optation or delegation care should be taken to preserve the ultimate responsibility of the elected members of local authorities, both for finance and for the general principles of administration. But this ultimate responsibility need not involve the administration of detailed matters exclusively or even predominantly by councillors.

It is also possible to enlist the help of more interested citizens in a consultative capacity or in organizing supplementary services. For example, there are at present voluntary committees (sometimes representing the mothers of the children concerned) assisting in the work of many publicly controlled infant welfare centres.

### VOLUNTARY PERSONAL SERVICE AS AN EDUCATION IN CITIZENSHIP

Apart from all questions of the value of the voluntary social worker or the voluntary administrator in the particular branch of social service in which he is engaged, his active participation in social service may be of immense value in his education as a citizen.

In our present system of political democracy we expect both very much and very little of the average citizen. At the rare intervals of elections we appeal to him as the supreme arbiter of our destinies, whose opinion on all the varied and complicated issues of the moment is of equal value in the ballot box with the opinion of any other individual. In between elections we collect his rates and taxes, but otherwise do nothing, in most cases, to help him to appreciate the nature of his duties as a citizen or to participate actively in them. We have accepted political democracy, which assumes that the ordinary citizen has enough interest in and knowledge of public affairs to make an intelligent decision upon them, while making quite insufficient efforts to ensure that he has such an interest and knowledge.

Now the knowledge necessary for intelligent political action is of two kinds. We need information as to the facts of the kind derived from newspapers, books and lectures, and from informal conversations and discussions. But, with regard to social facts, such knowledge by itself may be of a superficial nature, a knowledge of facts merely as external phenomena, without appreciation of their significance as elements of personal experience. The urgent need for many of us, in our attitude to public affairs, is not so much that we should know more facts as that we should appreciate the significance of the facts which we already know. Our worst defects as citizens are defects of imagination: we find it difficult to extend the social feelings, which are natural to us with regard to those with whom we are brought into personal contact, to individuals whom we have never seen, and we also find it difficult to project ourselves in thought into situations of a kind which we have never experienced. Presumably these limitations of the imagination have always existed,

but in less extensive and more simply organized communities they were not so serious in their effects the citizen was concerned much more largely than he is to day with neighbours of whom he had personal knowledge and with familiar situations To-day the personal experience of the average individual is a very limited basis for an understanding of public affairs It remains limited even when supplemented by that of his friends and acquaintances, for those friends and acquaintances will tend to come from the same spheres of work, locality, and political or religious affiliation as those with which he already has personal acquaintance, and the wide class differences of present society greatly increase the limitation There is considerable danger that political controversy may resolve itself into a clash of interests between groups, whose members have no understanding of the attitudes of other groups, and no imaginative conception of the whole community whose interests State action claims to serve

Now active participation in the work of a voluntary philanthropic organization is one of the ways in which the experience of the ordinary citizen can be widened In some respects it gives the same kind of training in citizenship as many other varieties of voluntary organization, and it must be remembered how much British political democracy owes to the smaller democracies of chapels, Trade Unions, Friendly Societies, Co operative Stores, clubs, sports associations In active participation in any voluntary democratic organization the member learns to listen patiently and peaceably to expressions of opinion with which he disagrees, to abide by the result of a majority vote, to contribute to a joint decision, to elect representatives and to trust them when elected, and to judge and act in relation to the good of the organization as a whole instead of in relation to his own interests With regard to some of these elements of civic training the philanthropic society has less to give than various other types of voluntary organization, but, on the other hand, it has certain special elements to contribute The typical philanthropic society works to supply a particular form of relief or service to all who may require its help, and for that purpose it bands together as its supporters all who sympathize with its aims.

These supporters are often drawn from all classes, occupations, religious denominations, and (in the case of charities of national scope) localities, and they are drawn together not by their interests as members of their own groups but by a common interest in serving the whole community with regard to some particular form of social service. The society is, for a particular purpose, a microcosm of the 'social service State,' and any one who takes an active part in it is to that extent better able to realize the nature of the problems of social service administration confronting Parliament and local authorities. He learns something of the nature of the work of administration and of the kinds of decisions which must be made by administrators. He gains some experience of the collective raising and expenditure of money. For the time being he forgets his personal and sectional group interests in helping to deal with the needs and problems of the whole community with regard to the service supplied by the society. If he deals personally with some of the clients of the society he probably comes across many types of conditions, experiences, and problems of which he would otherwise have no direct knowledge. He is given the opportunity both of fulfilling some of the duties of citizenship actively in a small sphere and of making himself better able to use his vote intelligently with regard to wider questions.

There is another aspect of the education in citizenship given by philanthropic activities which applies to voluntary charity as well as to voluntary personal service. A great many people are apt to regard the State (and to a smaller extent, its subordinate local authorities) as something entirely external to them. This attitude results partly from the mere size of the population and the consequent scale of State activities. It results also from the fact that, apart from elections, the average citizen experiences the State mainly as an entity which commands and enforces his obedience to the law and his payment of taxes. In his experience of the local authority he is more likely to appreciate the positive services rendered, but in neither case is there much scope for the actions of the public authority or his relations to it to be modified by his voluntary actions. This absence of any voluntary element in his citizenship leads to an attitude of

irresponsibility, he does not regard the public authority as a body for whose actions he is jointly responsible, and he finds it impossible to reverse this attitude completely on the few occasions when, as a voter at elections, he is given the chance of exercising responsibility (One evidence of this is the small proportion of electors exercising their vote at local government elections) Another result of the passive attitude of many people towards the activities of the State is that they are easily induced to view them as 'the will of the community' or 'Government interference' (according to their general bias for or against State action) without an examination of the purposes and methods of the particular activities in question Instead of regarding the State as an organization of the community for certain purposes, to be judged by the nature of its actions, they endow it with semi-magical attributes and regard its actions as outside the canons used in judging the actions of individuals or of other kinds of groups

These undesirable attitudes of irresponsibility and of an unrealistic attitude towards State activities are less likely to exist the more the citizen is concerned in philanthropic activities—in giving voluntary service to public authorities, or in giving voluntary service or voluntary donations to philanthropic organizations, especially if these are doing work somewhat similar to that of public authorities Take, for example, the person who contributes to the support of the local voluntary hospital If he thinks about the matter he is likely to realize both that he is making himself partly responsible for a joint activity and that the hospital is serving definite purposes and enlists his support according as to whether he approves of those purposes and of the means adopted to further them If he can extend that attitude to the very similar public health activities of his local authority and to the somewhat similar public health activities of the Ministry of Health he is developing a responsible and realistic attitude to politics

It is possible that some future form of political and industrial organization may give to the ordinary citizen many such opportunities of training in citizenship outside the sphere of philanthropic activities, but at present such opportunities

are scarce. Many other voluntary organizations give him experience of problems affecting special sections of the community, but few give him experience of problems affecting the community as a whole. If, on the basis of the argument in Chapter I, the public authority becomes responsible for much that is now done by philanthropic organizations, a good many of those participating in these organizations will lose a very valuable form of political education. Some of those concerned might transfer their personal service and financial help to those branches of social service in which, on the basis of the argument in Chapter II, there is plenty of scope for the voluntary organization. But it is desirable also that public authorities should welcome the services both of more voluntary social workers, in suitable cases, and of a larger number of voluntary administrators for particular branches of public work (as was developed in the argument above). They should do this both because their work would benefit by drawing on a larger number of citizens to help with their specialized interest and capacities, and because they would enable those citizens to fulfil some of their civic duties actively and voluntarily, and by so doing to fulfil their other duties with more responsibility and intelligence.



## CHAPTER IV

### PHILANTHROPY AND SOCIALISM

#### INTRODUCTION

A CONSIDERATION of what would be the place of philanthropy in a socialist Britain is necessarily of a very speculative nature. But I am tempted to discuss the relations between philanthropy and socialism as applied to British conditions, firstly, because as a socialist I am interested in trying to relate my belief in socialism and my belief in philanthropy and, secondly, because I think that the subject has not been sufficiently considered either from the angle of approach of the philanthropist or from that of the socialist. As was noted in Chapter I, the most systematic theories on the place of philanthropy have been developed by individuals connected with the Charity Organization Society, and those holding these theories have usually disliked socialism both in its general economic aspects and as affecting the administration of the social services. They have tended to regard socialism as a system of rigid bureaucratic control which would eliminate the elements of spontaneity, elasticity, experiment and individual treatment of particular cases which they consider to be of great value in philanthropic enterprise. Socialists, on the other hand, have tended to distrust charitable effort because of its inadequacy and patronizing spirit, and have regarded it as merely a temporary palliative which the coming of socialism would supersede and render unnecessary.

It is not relevant to the subject of this enquiry to discuss the general arguments for and against socialism. But I shall discuss to what extent the replacement of our present economic system by a socialist system would alter the conditions which at present evoke philanthropic activities, and to what extent the ideals and methods of socialism are compatible with the ideals and methods of philanthropy.

I understand by socialism essentially the ownership and control of the main economic enterprises of the community by public bodies of some kind, in order to give to all individuals equal opportunities to develop their capacities for their own fulfilment, and for the service of the community, and incomes sufficiently equal to provide the material basis of a satisfactory life for all, and to establish social equality. I should not consider it necessary for all economic enterprises to be publicly organized provided that the main framework were organized by public bodies. Those enterprises which were socialized need not necessarily be conducted directly by the State: local authorities, *ad hoc* public bodies, associations of consumers, and forms of international organization would all play their part, and trade unions and other associations of workers would be given more positive and constructive functions than they have to-day. I am envisaging socialism as it would work in this country and as achieved by constitutional methods and functioning under conditions of political democracy.

Such a socialist system would, at any rate in its early stages, leave the main income of an able-bodied adult individual to be provided by his own earnings, and a drastic curtailment of the present rights of inheritance would ensure that ultimately very few such individuals could live without working. The main economic burden of the support and education of children would be borne by the State through a system of family allowances supplemented by other types of assistance, and the work of mothers would be recognized as a most important form of service to the community, requiring adequate financial resources. There would be more free communal services than are provided at present. Provision for sickness and old age would be made by the State, possibly supplemented by insurance schemes. The State would provide maintenance for the unemployed and would do everything possible to reduce unemployment to very small proportions by control of the employment policy of individual industries, by control of currency and credit, and by schemes of public works. There would be no control of the mode of expenditure of individual incomes, but some kinds of State assistance would be given in the form of particular goods and services (as they are at present).

## THE PLACE OF CHARITY IN A SOCIALIST COMMUNITY

It is obvious that under such a system there would be far less need for many forms of charity than there is to-day. Higher wages, financial provision for children, and adequate provision for the sick, the old and the unemployed would mean that there was little need for charity to assist cases of poverty and sickness. On the other side of the picture the number of rich individuals would be much reduced and charitable organizations would have to depend much more than they do at present on small contributions from large numbers of people.

However, there would still be scope for various types of charity. Some charity would still be needed to supplement even those types of provision made by the State. However satisfactory in general no systematic schemes can provide for all the exceptional kinds of need which do in fact occur, though public schemes of social services could be made less standardized and more elastic than they are at present. An excellent point about many charitable organizations is that they give a great deal of individual attention to special cases and that they tend to be less bound by rules than public bodies, they could develop further this part of their work if they were freed from the calls on their time and financial resources due, under present conditions, to the inadequacy of public provision. They could specialize on giving information and advice rather than financial help to most of their applicants, and they could concentrate their financial help on cases of exceptional needs not adequately provided for by public authorities. They could act as interpreters to their applicants of the social service activities of public authorities and, from the other side, they could interpret the desires and needs of their applicants and of their supporters to public authorities.

There would also still be scope for charity in some of those forms discussed in Chapter II, for there are inherent limitations of even a socialist State. The four types of charities discussed in that chapter were supplementary, experimental, controversial, and international charities.

With regard to supplementary charities there would be

less and less scope for these in any organized form the more fully the community advanced to conditions of social equality and equality of income. The motive for supplementary charities lies in the different levels of expenditure and standards of life existing at present in different classes of the community. In a socialist community there would still be large differences in tastes and standards between individuals but there would not be our present stratification of incomes and occupations. Individuals would still wish to give unorganized charitable assistance to cases of need among their family and friends but, in a community with substantial social and financial equality, they would not feel so many financial obligations as they do at present to wider circles of people of their own class or occupation.

A socialist State should encourage far more experiments by public authorities than are engaged in to-day, but there would still be scope for experimental charities. A public authority cannot make experiments which have not the support, or at least the tacit consent, of the majority of the citizens whom it represents, and many desirable innovations in social services do not, in their early stages, appeal to the majority of citizens.

With regard to controversial charities, including religious and propaganda organizations, there is no reason to suppose that there would be fewer subjects of controversy in a socialist community than in our own, though some of the subjects would be different. The State would probably adopt the views of some of the present organizations, making their work unnecessary. On the other hand it is possible that some activities now organized or subsidized by the State would be left to voluntary organizations. For example, it is possible, though not in my view likely, that a British socialist State would cease to give any form of religious instruction in its schools. In that case religious organizations would strive to increase their educational and propaganda work in Sunday Schools and similar institutions. My belief in the value of propaganda organizations is part of my belief in democratic principles, and I consider that such organizations would play a necessary part in a democratic socialist community.

With regard to international charities it is particularly difficult to envisage the position, because this involves assumptions as to the state of affairs in other parts of the world as well as Britain. It is reasonable to assume that a socialist State in Britain would be far more willing to use some of its resources for the relief of distress in other countries than is the present British State. There would be at least two reasons for this. Socialists are markedly aware of the economic interdependence of the nations and peoples of the world and might reasonably argue that in many cases British interests would be furthered by the relief of distress in other countries. In addition most socialists are considerably more internationally minded than many of their opponents: they envisage the nation State of the future not as the present 'sovereign State' but rather as a provincial authority functioning as an integral part of a wider international organization. It seems likely, however, that there would remain ample scope for international charities for a long time to come. Even when war is abolished, with its accompanying calls on charity, there will remain great differences in the resources and efficiency of organization of different countries. Also the important type of international philanthropic activity conducted by missionary societies is of a controversial nature and unlikely to be engaged in by the State.

#### THE PLACE OF VOLUNTARY PERSONAL SERVICE IN A SOCIALIST COMMUNITY

The scope for voluntary personal social service in a socialist community is likely to be greater than at present. The term 'voluntary social service' or 'voluntary personal service' was defined in the Introduction to this book as including all voluntary unpaid service rendered by an individual to other individuals or groups, except that rendered to his family and personal friends. The discussion in Chapter III was concerned almost entirely with voluntary personal service in the work or administration of social services, but there is also much voluntary service rendered to voluntary and public organizations with other purposes, for example,

the work of unpaid trade union secretaries or of members of the electricity committee of a borough council. The socialization of many industries would probably involve a large amount of unpaid administrative work and would give to the industrial worker the opportunity to use his specialized knowledge in such work. This seems to be the case in Russia: for example, in their book 'Soviet Communism a New Civilization' Mr and Mrs Sidney Webb state that (in 1935) 'It is estimated that in the aggregate, apart from such salaried staff as exists, as many as 50,000 citizens are, at any moment, participating in the administration of Moscow, and nearly as many in that of Leningrad'. Russia has provided examples of some new forms of voluntary personal service. One of these is the work of 'subbotniki,' individuals giving voluntary service, usually manual labour, for a particular piece of work. For example, Mr and Mrs Webb state that 'More than two hundred thousand men and women of all ages from practically all the factories and offices of Moscow, volunteered their services on various free days during nine months in order that the first twelve-mile section (of the Moscow underground railway) could be opened on the seventeenth anniversary of the October Revolution'. Such voluntary service in manual work is very rare in Britain, except under war-time conditions, owing partly to the fact that, as most industries are conducted for private profit, they are not regarded as forms of public service in the same way that they are in Russia. Under socialism there would be less distinction between the attitude of the citizen to 'social work' and to other forms of service to the community. Another new form of social service which has developed in Russia is the system of 'shefstvo' or 'patronage' in which, to quote again from Mr and Mrs Webb, 'a group which is better organized, economically stronger, and politically more conscious, assumes, with respect to a group which is less well organized, economically weaker, and politically backward, the special responsibility of material and moral assistance'. For example, a patronage society among officials in a government department assumed 'patronage' over a struggling collective farm and 'supplied this collective farm with elementary manuals on book-keeping, a type-writer and other office requisites. The

members of the patronage society arranged to spend their annual holidays, in batches extending over three or four months, on the collective farm itself, where they helped in the farm work, looked after the accountancy, and generally educated the 'agriculturists of all ages'. It is unjustifiable to assume that such forms of social service as these would develop in the very dissimilar conditions of Britain. But it is interesting to note that even under the Marxian communist type of socialism, which is in some ways antipathetic to the ideals and methods of philanthropy, there have developed numerous forms of expression for the philanthropic spirit in voluntary service.

In addition to the scope for voluntary personal service in socialized industry it is reasonable to expect that a democratic socialist community would encourage the extension of many of the types of voluntary cultural organizations existing at present, and their extension would be aided by the higher level of general education, higher wages, better housing conditions, and shorter hours of work which socialists believe would exist under socialism. Such organizations need the voluntary financial contributions of their members, but they are far more dependent upon the voluntary service of enthusiastic members who are willing to act as secretaries, organizers, and leaders.

#### ARE THE IDEALS AND METHODS OF SOCIALISM COMPATIBLE WITH THOSE OF PHILANTHROPY ?

The second question to be discussed is to what extent the ideals and methods of socialism are compatible with the ideals and methods of philanthropy.

The ideals and methods of socialists are, in my view, incompatible with those of the kind of philanthropic effort most typically represented by the Charity Organization Society. Of course from the widest point of view there is much in common in their aims. Both groups are concerned to further the material and spiritual interests of individuals with various types of needs by bringing to their assistance the material and spiritual resources of other individuals or groups. The contrast lies in the different assessment made of

the comparative duties of the individual and the community in providing for individual needs. The 'C O S point of view' assumes that in general the individual should be able to provide by his own efforts the necessities and comforts of life for himself and his dependants. Charity and the State should assist him in exceptional circumstances but should always do so, if possible, in such a way as to help him in future to make provision for himself without their assistance. This point of view has always stressed the importance of maintaining the financial responsibility of the family for its members. It has also tended to prefer assistance from voluntary agencies to assistance from public bodies, though in this respect the view has been considerably modified in recent years.

The 'C O S point of view' is incompatible with socialism because it assumes and approves of a state of affairs in which individuals are left to determine their economic position by their own actions, and the conduct of industry is left to private enterprise without positive control or planning by public bodies. In this view the State has merely the negative functions of preventing abuses and relieving distress as contrasted with the positive functions of planning and control of industry which the socialist desires the State to assume. The socialist would agree with the C O S that the welfare of any community depends essentially on the character of its individual members, but he would argue that under modern economic conditions many of the circumstances influencing the individual are completely outside his personal control and that it is the duty of the State to control those conditions so that they shall help him as far as possible to develop his own character and capacities.

One result of the general point of view held by the C.O.S. is that philanthropy tends to be regarded as a relation between individuals who are normally economically independent although they have certain mutual obligations. Socialists, on the other hand, regard philanthropy as one mode of expression of the mutual obligations of individuals who are both citizens and members of a community of persons and groups economically and culturally interdependent, whether or not the interdependence is recognized.



But I consider that there is not only incompatibility between socialism and certain types of philanthropy but also incompatibility between philanthropy and certain types of socialism, in particular Marxian communism. This incompatibility, while it is not complete, as is evidenced by the Russian examples given above, arises from the apparent tendency of Marxian communism to create a form of totalitarian State and from its emphasis on 'the class struggle'. These two points will be dealt with in turn.

A totalitarian State, whether Fascist or Communist, would certainly allow many forms of philanthropy to continue. But it would tend to regard philanthropic activities with suspicion unless they were in line with the ideals and methods of the State, and it would suppress them if they were in opposition to these ideals and methods. Many voluntary organizations would exist, as they do in Russia, but they would be regarded as alternative forms of organization for the furtherance of the same purposes as were furthered by public bodies. In contrast to this conception of the relation of the State to voluntary organizations a democratic community regards voluntary organizations as expressions of the wishes of their members on certain aspects of life. As such they may, on occasion, have claims on their members equal to or greater than that of the State. In such cases, while the State has ultimate legal authority, it has not necessarily greater moral authority than that of the voluntary organizations. Several examples were given in Chapter II of voluntary philanthropic organizations whose purposes are not in line with those of the State and, in some cases, are even in opposition to them. A democratic State does not penalize activities of which it disapproves unless those activities are illegal, and it strives to respect the opinions of minorities in the framing of its laws, it also allows propaganda against the government. Cases will arise even in a democracy in which legal penalties are inflicted on individuals or groups for actions which those individuals or groups consider to be right, but such cases are much rarer than in a totalitarian State and democracy is therefore much more favourable to philanthropy, as it is also to other forms of voluntary group activity.

The second ground of incompatibility between philan-

thropy and Marxian communism arises from the latter's emphasis on 'the class struggle'. The Marxian communist regards the class struggle not merely as something in fact existing in capitalist society (with which interpretation I should agree) but as an aspect of social relations to be emphasized both in socialist propaganda within a capitalist community and in the socialist community when established. A great advantage of this emphasis is that it minimizes all the differences other than class which exist in the world to-day—divisions of race, nationality, occupation, sex and religion are of little importance to the Marxian, and both the State action and the philanthropic activities which a Marxian communist State would encourage would be most catholic in ignoring these distinctions. Yet to penalize individuals on account of their 'class origins' is as contrary to the humanitarian spirit of philanthropy as to penalize them for any of these other reasons. Such discrimination regards individuals merely as members of a particular group without considering their individual rights, needs and aspirations. If it be argued in reply that capitalist society does in fact make this discrimination (though in the reverse direction) I would urge that, while this is true, yet philanthropy has usually tried to adjust the balance and to be responsive to the needs of individuals of all groups and classes.

The above argument states my view that certain types of philanthropy are incompatible with certain types of socialism. But I see no incompatibility between a democratic socialism and a philanthropy which recognizes the part played by general economic conditions in determining the possibilities of individual action. Philanthropy would provide a most valuable check on the possible tendencies of a socialist State to standardize human activities unduly and to ignore individual variations of needs and ideals. Furthermore, any socialist State would demand continually from its citizens an imaginative and intelligent public spirit which is to-day demanded by the State only in times of crisis. Such public spirit cannot be produced to order—it is fostered at present by many forms of philanthropy, and a socialist State would do well to encourage philanthropic activities for this reason alone.

## CONCLUSION

Although there would remain considerable scope for charity in a socialist community yet its relative importance would be smaller than it is to-day. On the other hand the scope for voluntary personal service would be increased and the philanthropic spirit would be expressed more in the form of personal service than in the form of gifts of money. This change is to be welcomed. The value of personal service in educating the participants and as an expression of citizenship is far greater than the value of voluntary financial contribution. Also charity, however wisely given, often runs the risk of creating a feeling of patronizing superiority in the donor and of subservience or resentment in the recipient. Personal service is not so likely to create these feelings, and the likelihood would be far less in a society of social and economic equals. In such a society personal service would cease to be predominantly concerned with the succouring of those in poverty and distress and could devote itself to the innumerable ways in which human life can be enriched by voluntary mutual service and group activities. The raising of the general level of education would mean that far more people would have something of value to contribute to their fellows: the contribution would depend on the personal qualities and interests of individuals and there would cease to be any general social distinction between givers and receivers or leaders and followers. The idea of democracy assumes that each citizen has a unique contribution to make, and socialism would provide the conditions of educational opportunities, economic security, and social status which would enable him best to make this contribution.

The socialist does well to remember that, while it is his aim to use the resources and machinery of the State to ensure to every individual the possibility of a good life, yet, in the words of Francis Thompson,

'There is no expeditious road  
To pack and label men for God,  
And save them by the barrel-load'

Socialism will need for its realization all the resources of idealism, goodwill, group loyalty, imagination, and con-

structive ideas existing in the community, and it cannot provide adequate expression for these in official organizations and paid work alone. Philanthropy, in its widest sense, should find fuller scope in a socialist society than it does to-day

"

## CHAPTER V

### THE VOLUNTARY CITIZEN

AMONG the many urgent social problems of the present day one of the most important is that of evolving the right relationships between the State and its citizens. The philosophy of economic individualism no longer provides an adequate basis for ensuring the best possible conditions of a good life for all individuals. On the other hand the philosophy of the totalitarian State substitutes the means for the end, and in so doing sacrifices for the sake of the supposed interests of the State both the freedom of development of its own citizens and the welfare of citizens of other States. We are faced with the very difficult task of combining a large degree of public control of economic life with a preservation and extension of the spirit of democracy.

In this task philanthropy can give great assistance. Philanthropy is essentially an expression of voluntary citizenship. With all its defects it has embodied this ideal to a large extent in the past, and it could do so in even greater measure if its peculiar functions were better realized both by those engaged in it and by public authorities and the general body of citizens.

It is important that those engaged in philanthropy should realize both its possibilities and its limitations. One of the great merits of philanthropy is its prompt and spontaneous response to an apparent need of any kind. In innumerable cases individuals and voluntary organizations have recognized unsatisfied needs and have made efforts to provide for them long before these needs were recognized and provided for by public authorities. Voluntary effort is not deterred by the magnitude of the need in comparison with its slender resources, nor by the fact that the existence of the need may not be recognized by the majority of citizens. Its function in pioneer

and experimental work is of very great importance those engaged in such work are not only relieving the needs of the moment but are extending and enriching the whole conception of citizenship. The very fact that in the provision of many social services charitable expenditure is now of such small quantitative importance in comparison with public expenditure is evidence of how well experimental charities have done their work. They have convinced the general body of citizens of the necessity of comprehensive provision for these particular types of needs, and therefore their own partial provision has ceased or diminished into comparative insignificance. When the need for a particular form of social provision becomes a commonplace we are apt to forget the essential part played by those pioneering individuals and associations that helped to make it so.

The contribution of charity to social welfare could become much greater if those who organize and contribute to charitable effort would concentrate this effort to a larger extent on spheres of work which public authorities are unable or unwilling to undertake. The financial resources of charity are so small in comparison with those of the State that it is a wasteful use of those resources to attempt a partial provision for types of need for which only public funds are adequate and for which those funds could be used with the approval of the majority of citizens.

The problem of the supersession of charitable finance in spheres of work for which public authorities are willing to assume responsibility would be simplified if it were realized that voluntary administration and charitable finance need not necessarily go together. The unwillingness of some voluntary associations to surrender their work to public authorities is due partly to their fear that the ordinary public machinery would lose many of the elements of specialized interest, elasticity of organization, and goodwill of supporters enlisted by the voluntary agency. There are some grounds for this fear, and public authorities should take more trouble than they do at present to enlist the services of those interested in particular social services as voluntary social workers and as voluntary administrators. It is desirable that more use should be made of the powers to co-opt on to the committees

and sub-committees of local authorities and that in some cases the detailed administration of particular social services should be delegated to *ad hoc* bodies

An effort to enlist the active services of a larger number of citizens in the work and administration of the public social services would probably meet with many difficulties, and it would be necessary to ensure the ultimate responsibility of the elected members of public authorities. But such an effort would justify itself both by making available for public work the specialized abilities and interests of many citizens whose capacities are at present not enlisted and by affording to many people a training in intelligent and imaginative citizenship by giving them a practical insight into the work and problems of public authorities

The excellence of the work of a democratic State depends largely upon the quality of its citizens. Individuals do not become intelligent and public-spirited citizens merely by keeping the law, paying rates and taxes, and recording their votes at elections. They require opportunities of insight into the lives of their fellows and into the practical work of group administration. This kind of insight is given by active participation in the work of voluntary associations and of public bodies alike. It is all an expression of voluntary citizenship. The qualities of citizenship desirable in the democratic community of the future are far more likely to be developed by this kind of means than by methods of mass propaganda and deification of the State.

The citizenship which is expressed in the work of voluntary associations has often worked for purposes approved by the State at the time, or which have come to be approved by it later. But there have been and will continue to be cases where the work of voluntary associations has not been in line with the activities of the State and has even been in opposition to those activities, and to regard such work as an expression of citizenship may seem paradoxical. The paradox ceases to exist only if the loyalty desired from the citizen is regarded as a loyalty not so much to the present State and its actions as to the community of individuals both in his own and other countries for whose welfare both States and other forms of association exist. The State alone is an

inadequate object for the expression of the social impulses and obligations of the individual. It is inadequate because it includes only the national community, it is inadequate also because it cannot provide for all the varied needs and ideals of its citizens. The individual who gives expression to his social ideals in work for voluntary organizations as well as in work for the State will become in so doing a better citizen, for he will realize that his loyalty is not to the State itself but to the human purposes which it exists to serve.





**SECTION II**  
**THE INCOME OF CHARITIES IN ENGLAND**  
**AND WALES: A STATISTICAL SURVEY**



## CHAPTER VI

### THE SCOPE AND LIMITATIONS OF THE AVAILABLE FIGURES

#### THE LIMITATIONS OF THE AVAILABLE FIGURES

I STARTED on my investigation into the income of charities in England and Wales with a number of questions to which I wished to find an answer. I felt that both economists and statisticians had unduly neglected the subject of charity and that it would be very interesting to try to ascertain the quantitative importance of charity as affecting the distribution of wealth in this country, particularly as compared with the importance of public expenditure on the social services. I wished also to test the truth of some assertions which are often made by the ordinary person with regard to charitable finance, particularly the assertion that in recent years there has been a large decrease in the amount given in charity because of the decreased ability of donors to give owing to the increase of taxation, and because of the decreased willingness of donors to give owing to the provision of social services by public authorities.

One reason for the neglect of the subject by statisticians soon became apparent--the scarcity of general information. The expenditure of both the central government and local authorities must be approved by the representatives of the electors and therefore information is collected and published. Charitable organizations are, in most cases, responsible only to those contributing to them, and there is neither general publication of their accounts nor much assembling of information as to the total expenditure of all the organizations working in a particular field. The greater part of charitable finance does not come under any supervision by public authorities. Three classes of charities only must send reports to public authorities. These classes are endowed charities, which are

under the supervision of either the Charity Commissioners or the Board of Education and must send annual reports to these bodies, and war charities and charities for the blind, which must register with the appropriate local authority and send annual statements of accounts to it. But even with regard to these classes of charities there are no statements of finance published by most of the supervizing authorities. In addition there is public supervision of one type of charitable collections for all classes of charities—street collections, including flag-day collections, and some police authorities publish accounts of the total receipts in their areas from these collections.

The position is summarized by Professor Carr-Saunders and Mr Caradog Jones in the chapter on ' Voluntary Transfer from Rich to Poor ' in their book ' A Survey of the Social Structure of England and Wales ' . They state ' It is not the duty of any Government department or official to collect information about charities as a whole . The task does not seem to have been attempted by any private society or person . It would indeed be hardly possible to arrive at figures of any value as the result of private inquiry . For complete information on this matter we must wait until all charities are compelled to register and to render financial statements ' .

I entirely agree with the authors just quoted that it is impossible from the available information to ascertain any accurate figures of charitable income over the whole country. The difficulty is not only one of the scarcity of information but also of the many differences of classification which appear in the accounts of different charities. I would emphasize at this point that there are probably very few groups of figures given in this Section which are completely accurate. If the various Tables compiled should give the reader a deceptive impression as to the exactness of the figures used I can only plead that they have been constructed in an effort to extract *some* information of value from the statistical material available. I hope that one result of this survey will be to encourage those concerned to collect and publish a much larger amount of accurate information.

I felt, however, at the beginning of my enquiry, that there

was enough information available to indicate some conclusions of general interest, and this presumption has been confirmed by the figures assembled in this survey. The general conclusions which emerge are conclusions as to the *kind* of amount of the receipts of charities, as to the relative importance of different types of receipts of charities, and as to trends in charitable finance over recent years. In the three following chapters these conclusions are stated with regard to particular groups of charities, and in Chapter XI they are stated with regard to all charities in England and Wales.

### THE SCOPE OF THE AVAILABLE FIGURES

This survey is based mainly on three sets of figures, all of them collected and published by voluntary organizations. Chapter VII covers charities in London for the years 1908-1927. The figures are those for 'institutions in or available for the Metropolis' compiled by the Charity Organization Society and published by them in 'The Annual Charities Register and Digest'. These figures cover not only London charities but also a certain number of charities in other places and many national charities. They are the only general set of figures known to me giving information for all years between the pre-War and the post-War period, and they are therefore most valuable as an indication of trends over that period. Chapter VIII covers charities in Liverpool in 1907 and from 1923-1933. This chapter is based mainly on the figures collected by the Liverpool Council of Social Service and published by them in 'The Liverpool Quarterly' and its predecessor. These figures are valuable as showing the position of charities located in one area and as extending to a more recent date than the London figures. Chapter IX covers voluntary hospitals in the whole of England and Wales from 1924-1934. This chapter is based on the figures collected by the Central Bureau of Hospital Information and published by them in the annual 'Hospitals Year Book' and its predecessor, and on the figures collected by the King Edward's Hospital Fund for London and published by them in their annual 'Statistical Review of the Work and Finance of the London Voluntary Hospitals.' The hospitals figures are

valuable because they cover the whole country, because they include a much larger proportion of their field than do the figures for London and Liverpool, because they have adopted certain uniformities of classification, and because they give information as to various types of charitable gifts.

Chapter X, assembles a rather miscellaneous group of other kinds of available information. It includes figures for three classes of charities which are not included in the total figures for London and Liverpool and which I have excluded from my estimates for the whole country. The first of these classes is purely endowed charities, that is charities which receive no income other than from endowments. There is no recent collected information on the finance of these charities and I have excluded them from the total figures for this reason and because my interest is in the charitable interests and actions of people living now, not in those of the charitably inclined of past periods. The second class of charities excluded from the total figures is purely religious charities, that is charities for religious purposes only. (Religious charities for social or educational work are included.) Religious charities fall under the general definition of charities given in the Introduction to this book, but they are not concerned with general social services and they seem to me to be a special case which would require a detailed study of its own. The third class of charities excluded from the total figures is political organizations. As is explained in the Introduction, I have included political organizations, as well as other organizations for propaganda, in my definition of charities, although this is not in accordance with ordinary usage. But the available information on the finance of political organizations is so inadequate that it would be impossible to include their receipts in my total estimates, even if it were desirable to do so.

With the exception of the three classes of charities just described all classes of charities and all types of their receipts are included in the estimates for the whole country in Chapter XI.

No comparison has been attempted between charitable finance in England and Wales and charitable finance in any other country. But the reader who is interested in the

position in the United States of America may be referred to the investigation by Mr Willford Isbell King published under the title 'Trends in Philanthropy'. This is a study of 'a typical American city'—New Haven, Connecticut, with a population of 188,000 in 1925. The investigation is for the years 1900–1925 and the figures cover a large proportion of the total receipts of charities in the city. I know of no similar investigation in an English town. The nearest approach to such an investigation is Dorothea C. Morison's survey of public and charitable expenditure in Cambridge, which is included as a sample in Chapter XI.



## CHAPTER VII

### CHARITIES IN LONDON 1908-1927

#### SCOPE OF THE FIGURES

THIS chapter is based on the annual 'General Summary for the Year' appearing in the 'Annual Charities Register and Digest' published by the Charity Organization Society. The summaries cover the years 1908 to 1927. There was some less complete information published for a few years earlier. They were the work of the late Mr A Mursell, and since his death it has not been found possible to continue them. (A summary was again published in the Register for 1937.)

The phrase used to describe these tables is that they summarize 'The Finance of Institutions in or available for the Metropolis'. Thus the figures include a great deal more than purely London charity—they include many national charities whose head offices are in London, and they include a certain number of charities (e.g. Homes of various kinds) available for the use of Londoners but not situated in London. The extent to which this statement is true varies considerably as between the different classes of charities.

The figures do not include local endowed charities in London (whose income in about 1906 was estimated at a minimum of £420,000), nor do they include some other endowed charities. They do not include sums distributed by religious congregations, except when this is done through some other charitable institution. A note says that the majority of the Roman Catholic institutions are not included as they 'are under Episcopal supervision, and therefore do not report in the same way as purely secular agencies, and in a lesser degree the same remark applies to Anglican Sisterhoods. It is obvious that considerable sums are contributed to, and dispersed through, these channels'. 'Spiritual Institutions' are not included in the totals for all

charities, except when they combine spiritual work with material relief, but some information with regard to their finance is given separately

The tables in the Annual Charities Register do not cover the same number of charities each year. The total number covered each year is given in Table 1. (As no number is given for 1927, the number for 1925-26 has been given for each group of charities, when it is discussed separately, in comparison with the number for 1908.)

The annual tables group the charities covered in various classes—23 in 1927. For each of these classes information is given as to the receipts from charitable contributions, legacies, interest, payments by or for inmates, industrial operations, and sundries. Figures are also given for various categories of expenditure—with these I am not concerned.

There is probably some duplication in the figures as some charities make grants to other charities and in these cases the amounts may be included in the receipts of both sets of charities.

The figures for the various classes of receipts are less reliable than the figures for total receipts. Charities have not adopted uniform systems of classification and some items have been differently classified by different charities. For example, some payments from such sources as Hospital Saturday Funds may be regarded as either charitable contributions or as payments by or for inmates, and there have probably been some cases of subscriptions from public authorities which have been included, along with other subscriptions, as charitable contributions.

### RECEIPTS OF ALL GROUPS OF CHARITIES

Table 1 shows the receipts for the total of all the groups of charities over the nineteen years covered.

The number of charities varied from year to year with, on the whole, a considerable decrease over the period. The number included in 1925-26 was 1,108, only slightly more than two thirds of 1,606, the number for 1908. (In the years 1908-1916 and 1919-1920 there is no information as to the number of charities included in some group or groups, so that

the total for all groups exceeds the figure given by an unknown amount—this fact is represented by the + sign ) It is impossible to tell to what extent the decrease is an indication that the figures for later years are less complete, and to what extent it is due to the closing down of many charities or their amalgamation with other bodies

The one important change, of which I know, in the

TABLE I

RECEIPTS OF ALL GROUPS OF CHARITIES IN LONDON FOR THE NINETEEN YEARS 1908-1927

	Number of Charities (+ is plus)	Total Receipts	Charitable Contribu- tions	Legacies	Interest	Payments by or for Inmates	Indus- trial Opera- tions	Sundries
		£000s	£000s	£000s	£000s	£000s	£000s	£000s
1908	1,606+	8,479	3,825	1,181	1,034	1,759	647	33
1909	1,600+	8,469	3,823	1,034	1,063	2,111	417	22
1910	1,600+	8,430	3,719	990	1,095	2,182	426	18
1911	1,594+	8,366	3,817	949	1,122	2,231	412	35
1912	1,579+	8,673	3,800	938	1,158	2,342	399	15
1913	1,581+	8,306	3,534	994	1,128	2,176	484	12
1914	1,389+	8,921	3,523	1,467	1,199	2,336	386	9
1915	1,373+	7,660	3,318	899	1,198	1,799	430	17
1916	1,234+	8,437	3,801	1,073	1,260	1,580	713	9
1917	895	8,135	3,805	841	1,320	1,804	417	9
1918	1,060	9,884	4,618	1,009	1,360	2,114	771	11
1919	1,058+	10,880	5,349	792	1,447	2,500	766	26
1920	1,076+	13,607	5,131	1,714	1,686	3,165	1,409	169
1921	968	13,651	5,717	1,320	1,995	3,832	779	12
1922	1,012	14,890	5,935	2,096	2,143	3,982	708	26
1923	1,025	15,202	6,699	1,556	2,534	3,683	715	15
1924-25	1,005	14,965	6,193	1,387	2,654	4,115	605	11
1925-26	1,108	14,832	6,016	1,295	2,715	4,248	518	10
1927	?	15,001	6,142	1,419	2,699	4,277	450	13

inclusiveness of the figures over the period, is with regard to Reformatories. These were included as a group from 1908 to 1914. Then, owing to the absence in war-time of the usual official details, only very insufficient information was included in 1915 and 1916, and again in 1919 and 1920. In 1917 and 1918 and from 1921 to 1927 no information was included. The inclusion of Reformatories increased the figures of total receipts by between £440,000 and £550,000 in each of the years 1908 to 1914. A very large proportion of the income of Reformatories was in the category payments by or for

inmates, and the difference made by the inclusion of this class of charities to the figure of total charitable contributions never exceeded £35,000

Table 2 shows the proportionate changes from year to year, calculated as index numbers with the receipts for 1908 as 100. These index numbers are given for total receipts, and for the two classes of receipts which represent charitable

TABLE 2

INDEX NUMBERS FOR CERTAIN CLASSES OF RECEIPTS OF ALL GROUPS OF CHARITIES IN LONDON FOR THE NINETEEN YEARS 1908-1927  
(1908=100)

A=Money Income

B='Real Income' corrected for Changes in the Cost of Living

	A MONEY INCOME			Cost of Living (1908=100)	B 'REAL INCOME'		
	Total Receipts	Charitable Contributions	Legacies		Total Receipts	Charitable Contributions	Legacies
1908	100	100	100	100	100	100	100
1909	100	100	87	100	100	100	87
1910	99	97	84	101	99	96	83
1911	101	100	80	102	99	98	79
1912	102	99	81	105	97	95	77
1913	98	92	84	106	93	87	79
1914	105	92	124	105	100	88	119
1915	90	87	76	129	70	67	59
1916	100	99	91	153	65	65	59
1917	96	99	71	184	52	54	39
1918	117	121	85	213	55	57	40
1919	129	140	67	225	57	62	30
1920	161	142	148	261	62	54	57
1921	162	149	112	237	68	63	47
1922	176	155	178	192	92	81	93
1923	179	175	132	182	99	96	73
1924-25	177	162	118	184	96	88	64
1925-26	175	158	109	182	96	87	60
1927	177	160	120	175	101	92	69

gifts—'charitable contributions' and 'legacies.' As there were great changes in the cost of living during this period, the table also shows the index numbers for these classes of receipts when allowance has been made for the changes in the Cost of Living Index Number, also included in the table. (The basis for calculating the Index Number was rather different in the years prior to 1915 from that in 1915 and subsequent years) These index numbers of 'real income' indicate the changes in the purchasing power of their receipts

to the charities concerned at any rate more accurately than do the index numbers of actual income (For caution as to use of these figures see page 174)

#### TOTAL RECEIPTS

Total receipts rose from about £8½ million in 1908 to about £15 million in 1927—an increase of 77 per cent. The figure for 1927 was the highest for any year in the period except 1923.

The figures were very steady for the six years 1908–1913, when they varied only between £8·3 million and £8·7 million. They were again very steady, at a level about 77 per cent. higher, in the five years 1922–27, when they varied between £14·8 million and £15·2 million. An increase of total receipts from about £8½ million to about £15 million is therefore a pretty fair summary of the comparative pre-War and post-War position.

The figures for the War and immediate post-War period were not nearly so steady. The figures do not include war charities, whose income of course was considerable (e.g. the Annual Charities Register for 1917 states that up to September 1916 nearly £6 million had been subscribed to the National Relief Fund, and that in the first ten months of 1916 the Joint Finance Committee of the British Red Cross and the Order of St. John had an income of £3 million).

The large increase in total receipts over the period is, however, more than counterbalanced in most years by the rise in the cost of living, as is shown in Table 2B. From 1908 to 1914 'real income' remained fairly stable, except in 1913, when it fell considerably. From 1915 onwards it fell greatly, and until 1922 it was only 70 per cent. or less of the amount for 1914, in 1917–19 less than 60 per cent. In 1923 and after it was almost back to the pre-War level, and in 1927 it exceeded it by 1 per cent.

This contrast of money income and 'real income' shows very markedly the comparative steadiness of the receipts of charities in terms of money, and consequently the disadvantage of charities in times of rising prices, and their advantage in times of falling prices. It shows also that the rise of 77 per cent in money income between the beginning

and the end of the period only just sufficed to balance the rise in prices, so that the real financial position of the charities was approximately the same in 1927 as it was 19 years earlier

### PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME

Table 3 shows the proportions of the total receipts received in different classes of income at the beginning and end of the

TABLE 3

PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME IN ALL GROUPS OF CHARITIES IN LONDON, 1908 AND 1927

	Total Receipts		Receipts excluding Legacies	
	1908.	1927.	1908.	1927.
	%	%	%	%
Charitable Contributions .	45	41	52	45
Legacies . . . . .	14	9	..	..
<i>Total Charitable Gifts</i> .	59	50	52	45
<i>Interest</i> . . . . .	12	18	14	20
Payments by or for Inmates .	21	29	24	31
Industrial Operations . .	8	3	9	3
<i>Total Payments for Services Rendered</i> . . . . .	28	32	33	35

period. It also shows the proportions if legacies are treated as 'extraordinary income' and subtracted from total receipts. The general results of the comparison (on the second basis) are a drop of 7 per cent. in the proportion of charitable

contributions, a rise of 6 per cent in interest, a rise of 7 per cent. in payments by or for inmates, and a drop of 6 per cent. in receipts from industrial operations (which were, in 1927, an almost negligible source of income) The income from payments for inmates and that for industrial operations moved in opposite directions, so that the total income in payments for services rendered was a very similar proportion of total receipts at the beginning and end of the period—with a rise of 2 per cent

The following paragraphs give a summary of the movements of each of these classes of income over the period

#### CHARITABLE CONTRIBUTIONS

This category includes charitable gifts of all kinds except legacies It is not further divided It will be seen from Table 1 and Table 2A that the amount was very steady round about £3·8 million for the five years 1908-12 It then decreased considerably for three years, and returned to about the previous level in 1916 and 1917 After that it increased every year to a maximum of £6·7 million in 1923—75 per cent above the 1908 level—and settled down to about £6·1 million in the last three years of the period This amount was 60 per cent above the 1908 level and represented 41 per cent. of total receipts as compared with 45 per cent in 1908

From Table 2B it will be seen that in no year after 1909 was the real income represented by charitable contributions as high as in 1908 For the years 1915-21 it was less than 60 per cent of the 1908 level After 1921 it recovered considerably, but in 1927 was still only 92 per cent of that amount This result of changing prices is very much what one would expect. The annual subscriptions of individuals to charities tend to be stereotyped at certain round sums (e.g. a guinea, 10/-, 2/6) Other types of charitable gifts are not so fixed, but in general charitable donors, like other people, find it difficult to adjust their ideas of the value of money quickly to changes in the price level

#### LEGACIES

The Annual Charities Register in a note on legacies says that these are 'a fluctuating source of income, designed,

doubtless, in many cases to continue by means of interest the contributions of a deceased supporter, and on this ground counted as capital by the receivers'. On account of this variation from year to year it is more difficult to see the trend of the figures than with regard to the other categories of income, and, as it happens, in the base year of 1908 the figure was exceptionally large. A comparison of the average of the five years 1908-12 with the five years 1922-27 shows that legacies increased from about £1 million to about £1½ million, an increase of 52 per cent. This increase was not sufficient to balance the increase of prices, and real income decreased in the average of 1922-27 to 84 per cent of its amount in 1908-12. Its proportionate importance as a source of income had fallen as between the two periods—from 12 per cent of total receipts to 10 per cent.

Thus, although legacies represented a smaller proportion of total receipts at the end of the period than at the beginning, and, although they had not increased as much as either the price level or the amount of other charitable gifts, the London figures do not support the often expressed impression that there has been a tremendous decrease in the amount of charitable legacies, due to the increase of the estate duties and other taxation, and to the increasing provision of public social services.

#### INTEREST

The amount of receipts in interest rose from about £1 million in 1908 to about £2.7 million in 1927. There was a rise every year except between 1912 and 1913, 1914 and 1915, and 1925-26 and 1927, when there were slight falls. The figures were not conspicuously affected by either the Great War or the changes in the price level, in contrast to the figures for total receipts and charitable contributions. The amount of money income from interest in 1927 was 162 per cent. higher than in 1908, and the amount of real income was 50 per cent. higher. It represented a much larger proportion of total receipts—20 per cent. instead of 14 per cent.

I find it difficult to suggest adequate explanations for these figures. The rise in the rate of interest would increase the yield of new funds available for investment. But there



must also have been great increases in the amount of capital possessed by the charities (about which there is no collected information) In view of the fact already stated that the real income represented by the total receipts of these charities was between 1914 and 1927 below the 1908 level, and for several years very much below it, it seems surprising that the charities should have found it possible to increase their capital It seems likely that considerable amounts of the sums received in legacies during this period were either in the form of legacies ear-marked for capital purposes or, if free legacies, were devoted to capital purposes But, whatever be the reasons for the large increase in interest, there is no doubt that it means a strengthening of the financial stability of the charities, as this source of income is independent of the momentary opinions and resources of either the donors to their funds or those benefiting from their services

#### PAYMENTS BY OR FOR INMATES

The amount received in payments by or for inmates rose from about £1½ million in 1908 to about £4½ million in 1927 The rise was fairly continuous except for the three years 1915-17 The figure for 1927 was the highest for the period and represented an increase of 143 per cent in money income and 39 per cent in real income It was a much more important proportion of total receipts—29 per cent instead of 21 per cent

There are three main classes of payments included in this category, but there is no information about the comparative importance of the different classes There are first payments by individual recipients of the services provided by the charity—these will be shown in Section III to have increased over this period in the case of two district nursing associations, and probably the same causes—the general rise in working-class incomes, and especially the diminution of the amount of extreme poverty—have caused their rise in the case of many charities

There are secondly payments by means of either compulsory or voluntary insurance—the increase of these has been very important in the medical charities.

There are thirdly grants from public authorities, which

have certainly increased very much with regard to some of the classes of charities included

It should be noted that the term 'inmates' is too narrow—it does not accurately describe, for example, those benefiting from domiciliary nursing services—but with regard to these tables it should be taken to cover all those benefiting directly from the services rendered by the charity in question

#### INDUSTRIAL OPERATIONS

This category of income includes receipts from industrial operations by the inmates of Homes, and trading operations undertaken by charitable agencies

The figures fluctuate considerably from year to year and there does not seem to be any particular trend discernible in them (See Table 1) Thus, while the figure of about £450,000 for 1927 is only about 70 per cent of the figure for 1908, the figures for the six years 1918-23 exceed the latter, and the figure for 1920 is about 80 per cent higher than that attained in any other year. In fact the figures for this category of receipts are an enigma to me<sup>1</sup>

#### RECEIPTS OF VARIOUS GROUPS OF CHARITIES

Table 4 shows separately the nine groups of charities which were, in 1927, the only groups receiving more than £400,000 in total income or more than £100,000 in charitable contributions. These nine groups together received in that year 89 per cent. of the total receipts of all charities, 93 per cent of charitable contributions, and 95 per cent of legacies

The other fourteen groups received between them 11 per cent of total receipts, 7 per cent of charitable contributions, and 5 per cent of legacies. These groups were, in 1927, Deaf and Dumb, Cripples, Inebriates, Feeble-minded, Epileptics, Incurables, Dispensaries, Nursing, Educational, Day Nurseries, Discharged Prisoners, Penitentiaries, Employment, and Emigration

It is interesting to note the comparative distribution of income between the different groups at the beginning and end of the period. On the whole the changes are small. There were considerable increases in the proportion of total receipts

going to the Medical, etc, group and to the Blind group, and Homes for the Aged, General Relief, and Social and Physical Improvement gained somewhat. On the other hand Convalescent Homes and Benevolent Institutions lost proportionately. With regard to charitable contributions the considerable proportionate changes were gains by the Blind, Homes for the

TABLE 4

PROPORTION OF RECEIPTS OF ALL CHARITIES IN LONDON GOING TO VARIOUS GROUPS OF CHARITIES, 1908 AND 1927

	Total Receipts		Charitable Contributions		Legacies	
	1908	1927	1908	1927	1908	1927
	%	%	%	%	%	%
Medical, etc	20.6	25.1	21.9	21.2	35.3	26.8
Convalescent Homes	4.3	2.9	4.6	3.2	2.9	1.2
Blind	4.0	6.8	1.9	5.4	3.2	8.4
Homes for the Aged and Pensions	3.3	4.3	3.7	3.3	3.9	4.7
Homes for the Young	13.2	13.2	15.3	18.2	20.2	23.3
General Relief	10.9	11.9	15.0	16.3	6.5	4.3
Benevolent Institutions	7.3	6.4	8.6	8.7	5.0	2.8
Social and Physical Improvement	13.6	14.8	14.4	12.7	3.0	7.7
Protection	4.0	4.0	4.2	4.4	9.9	15.6
Total of these Groups	81.1	89.5	89.6	93.5	89.9	94.8
All other Groups	18.9	10.5	10.4	6.5	10.1	5.2

Young, and General Relief, and losses by Convalescent Homes, and Social and Physical Improvement.

It is also interesting to note the differences between the preferences of donors to different groups of charities as between annual contributions and legacies. The Protection group received a much larger proportion of total legacies than of total charitable contributions, and the Medical, etc, group and Homes for the Young received larger proportions. On the other hand, the General Relief group received a much smaller proportion.

The following pages give a summary of the movements

over the period of the total income and the income from various sources of the nine main groups of charities listed in Table 4, in the order in which they appear in that Table

#### RELIEF IN SICKNESS AND MEDICAL AND SURGICAL AID

This group of charities (called 'Medical, etc,' in Table 4) includes all charities giving relief in temporary illness except Convalescent Homes (discussed below), Nursing (discussed in Section III), and Dispensaries (Dispensaries in 1927 accounted for only £26,000 of total receipts and £6,500 of charitable contributions) The Medical, etc, group had by far the largest income of any group in 1927, when it received about 25 per cent of total receipts, 21 per cent of charitable contributions, and 27 per cent of legacies The number of charities included in the group had risen from 152 in 1908 to 184 in 1925-26

Total receipts rose from about £1½ million in 1908 to about £3½ million in 1927—an increase of 117 per cent There was no tendency for receipts to rise between 1908 and 1912. From 1917 to 1922 they rose rapidly to a peak of £4½ million (which peak was partly due to exceptionally large amounts of legacies in that year) In the last four years of the period they varied between £3·5 million and £3·9 million

Charitable contributions rose from about £840,000 in 1908 to about £1·3 million in 1927—an increase of 55 per cent, somewhat less than the proportionate increase for charitable contributions to all charities They were much less important as a source of income—representing only 35 per cent instead of 48 per cent of total receipts There was no tendency for them to rise from 1908 to 1917, and they then (with the exception of one year) rose rapidly to a peak of £1·7 million in 1923 Legacies averaged about £450,000 for the whole period, and were round about £400,000 in both 1908 and 1927, with no indication of a rising trend They represented 10 per cent. of total receipts at the end of the period as compared with 24 per cent. at the beginning The proportion of interest to total receipts rose from 19 per cent to 22 per cent.—larger proportions than for all charities, but a smaller rise during the period

The outstanding change of the period was the increase of payments for inmates from £103,000 to about £1½ million—nearly twelve times as large a sum. The proportion of this sum

to total receipts rose during the period from 6 per cent. to 32 per cent. (The increase was fairly slow until after 1914.) There is no further division of this category of receipts, but it is fairly safe to state that there have been increases in all the classes of inmates' payments mentioned above, namely, payments by individual patients, payments by means of compulsory and voluntary insurance, and grants from public authorities. The change has revolutionized the financial position of this group of charities, and the generalization is true of this group that the function of charitable gifts has changed from that of paying the whole cost of the service for those too poor to help themselves in any way to that of meeting the difference between the cost and what those benefiting can afford to pay, either individually or through mutual insurance.

A large proportion of the income of the charities in this group is the income of the London hospitals. For these further information is given in Chapter IX, based on the figures collected by the King Edward's Hospital Fund. Among the other charities included are surgical aid societies, among them the Royal Surgical Aid Society, with an income in 1934 of £57,000.

#### CONVALESCENT HOMES

This group had in 1927 an income of about £440,000—3 per cent of the income of all charities. Income had risen from £368,000 in 1908—an increase of only 19 per cent. At the same time the number of institutions included had fallen from 217 in 1908 to 108 in 1925–26, so that probably a smaller proportion of the convalescent homes in existence are included in the later figures.

Charitable contributions had increased from £177,000 in 1908 to £198,000 in 1927—an increase of only 12 per cent. They represented between about 45 per cent and 48 per cent of total receipts at both dates. Legacies in 1927 represented 4 per cent of total receipts, interest 14 per cent, and payments for inmates 37 per cent, this proportion having risen considerably from 26 per cent in 1908.

This group of charities includes convalescent homes all over the country, many of them quite small. There is a note

in the Annual Charities Register that many homes are maintained at the cost of individuals, or communities, and the cost is therefore not ascertainable'

#### BLIND

Charities for the blind had in 1927 an income of about £1 million—8½ per cent of the income of all charities. The income in 1908 was £340,000, so that the increase during the period was almost exactly three times. The number of societies included had fallen from 94 in 1908 to 75 in 1925-26.

Charitable contributions had risen from £72,000 in 1908 to £334,000 in 1927—an increase of 366 per cent, i.e. to more than 4½ times their earlier amount. Their proportion of total receipts rose from 21 per cent to 33 per cent. This increase took place between 1912 and the peak year of 1921, when the amount was £484,000. Legacies accounted for between 11 per cent and 12 per cent of total receipts in both 1908 and 1927, and interest for between about 9 per cent and 10 per cent. Payments for inmates rose from 17 per cent to 28 per cent. In charities for the blind receipts from industrial operations are an important source of income, but one whose relative importance decreased greatly during the period—from 42 per cent to 18 per cent of total receipts.

Under the Blind Persons Act, 1920, charities for the blind which collect from the public must be registered with the council of the County or County Borough in which they are situated and must furnish annual returns to that council. Statistics from the returns furnished to the London County Council under this Act are given in Chapter X, page 153. Under the same Act, Counties and County Boroughs were made responsible for aiding the blind, either directly or through subsidizing voluntary agencies, and old age pensions were granted to the blind at the age of 50. Thus the position of relief to the blind was revolutionized, as they had previously been dependent on either charity or the poor law.

The figures for this group include charities in other parts of the country besides London, and also national charities. Of these latter the largest is the National Institute for the Blind (income 1929-30, £194,000). Those endowments for the blind which do not receive charitable contributions are not

included in the figures, and these furnish a considerable annual amount

#### HOMES FOR THE AGED AND PENSIONS

This group had in 1927 an income of £643,000—4 per cent. of the income of all charities. Income had risen from £277,000 in 1908—an increase of 132 per cent. (In 1908, however, few institutions were included in comparison with succeeding years—in 1908 only 13 institutions were included, in 1909 62, in 1925-26 52. So it seems better in this case to take 1909 as the year for comparison.) In 1909 the income of the group was £342,000, and the increase from 1909 to 1927 was 88 per cent.

Charitable contributions had increased from £134,000 in 1909 to £203,000 in 1927—an increase of 52 per cent. They represented 39 per cent. of total receipts in 1909 and 31 per cent. in 1927. Legacies in 1927 were 10 per cent. of total receipts. Interest had risen from 21 per cent. to 34 per cent. in spite of the fact that agencies deriving their income only from endowments are not included. Payments for inmates had risen greatly—from 6 per cent. to 24 per cent.

In some of the earlier years of the period figures are given separately for Homes for the Aged and for Pensions, and in these years about three-quarters of the total income of the two groups is the income of pensions societies. An example of a large pensions society is the Royal United Kingdom Beneficent Association, with an income in 1934 of £153,000.

#### HOMES FOR THE YOUNG

This group of charities had the third largest total income in 1927 and received 13 per cent. of total receipts, 18 per cent. of charitable contributions, and 23 per cent. of legacies. The number of charities included in the group had fallen from 241 in 1908 to 112 in 1925-26.

Total receipts rose from about £1.1 million in 1908 to about £2 million in 1927—an increase of 77 per cent. This increase was exactly the same proportion as the increase of total receipts for all London charities, and about the same proportion as the rise in the price level.

Charitable contributions rose from about £600,000 to about

£1·1 million—an increase of 91 per cent (They were steady at about that figure for the last three years of the period.) They represented a large proportion of total receipts, and an increasing proportion—57 per cent in 1927 as compared with 52 per cent in 1908. Legacies were about £240,000 in 1908 (21 per cent of total receipts) and about £330,000 in 1927 (17 per cent). Thus this group of charities gets an exceptionally large proportion of its income in charitable gifts. Interest in 1927 represented only 13 per cent of its total income and payments for inmates only 12 per cent, the latter proportion not having increased since 1908.

This group of charities comprises institutions in all parts of England (Roman Catholic institutions are not included). There are in the group three very large national institutions which receive between them an income of nearly £1 million. These are Dr Barnardo's Homes (income 1933, £511,000), the Church of England Incorporated Society for Providing Homes for Waifs and Strays (income 1934, £262,000), and the National Children's Home and Orphanage (income 1934-35, £210,000).

#### GENERAL RECAPITULATION

This group of charities had the fourth largest total income in 1927, when it received 12 per cent of total receipts, 16 per cent of charitable contributions, and 4 per cent of legacies. The number of charities included in the group had fallen from 190 in 1908 to 105 in 1925-26. Total receipts rose from about £920,000 in 1908 to about £1,790,000 in 1927—an increase of 115 per cent.

Charitable contributions rose from £575,000 to about £1 million—an increase of 74 per cent, almost exactly the same proportion as the increase in the price level. They represented a large proportion of total receipts, but a decreasing proportion—56 per cent in 1927 compared with 62 per cent in 1908. Legacies in most years were only a rather small proportion of total receipts in 1927 they were 3 per cent.—£61,000. The proportion of interest had increased greatly during the period—from 10 per cent to 24 per cent. Payments for inmates were comparatively unimportant—between 11 per cent and 12 per cent at both dates. Receipts from industrial operations had fallen from 8 per cent to 5 per cent.



The Annual Charities Register says of this group 'The class relating to general relief operations covers a wide field, and embraces shelter, relief in money and kind, general missions in which material relief operations are carried on as well as religious work, and the relief of special classes'

#### BENEVOLENT INSTITUTIONS

This group had in 1927 an income of £953,000—6 per cent of the income of all charities. Income had risen from £622,000 in 1908—an increase of 53 per cent. The number of charities included was very similar at the beginning and end of the period—86 in 1908, 81 in 1925—26

Charitable contributions rose from £329,000 in 1908 to £534,000 in 1927—an increase of 63 per cent. They represented a large and increasing proportion of total receipts—53 per cent in 1908, 56 per cent in 1927. Legacies in 1927 were £39,000—only 4 per cent. Interest was a large proportion and had risen from 25 per cent to 30 per cent. Payments for inmates had fallen from 13 per cent to 10 per cent, though the actual amount had risen. Receipts for industrial operations were negligible.

The Annual Charities Register says of this group that it 'comprises a large number which are, in a sense, friendly or trade societies, whose resources are supplemented by charitable contributions. In a great proportion membership is a condition precedent to assistance, and such agencies, therefore, differ essentially from an ordinary charitable institution'. Thus a good deal of what is classed as 'charitable contributions' is partly in the nature of voluntary insurance, the difference in many cases from other forms of voluntary insurance being that no definite rights to benefits attach to membership, but only rights to be elected to benefits. Most of the charities in this group are attached to particular occupations or industries, but in some cases there is another basis of membership, as in the Royal Masonic Benevolent Institution (income 1934 £152,000) for aged freemasons and their widows. Examples of benevolent institutions for particular occupations or industries are the Railway Benevolent Institution (income 1934-35 £92,000), the Benevolent and Orphan Fund of the National Union of Teachers (income 1934

£52,000), and the Royal Agricultural Benevolent Institution, (income 1934 £47,000).

#### SOCIAL AND PHYSICAL IMPROVEMENT

This group of charities had the second largest total income in 1927, and received 15 per cent of total receipts, 13 per cent of charitable contributions, and 8 per cent of legacies. The number of charities included fell from 145 in 1908 to 72 in 1925-26 the number had not varied very much since 1917. Total receipts rose from about £1,150,000 in 1908 to about £2,220,000 in 1927—an increase of 93 per cent.

Charitable contributions rose from £550,000 in 1908 to £778,000 in 1927—an increase of 42 per cent. Their proportion to total receipts fell considerably—from 48 per cent to 35 per cent. Legacies in 1927 were £109,000—only 5 per cent of total receipts, this figure had been very steady for the last five years. The proportion of interest to total receipts had risen greatly during the period—from 2 per cent to 12 per cent. There was a great jump in the receipts from interest from £66,000 in 1920 to £274,000 in 1921. Payments for inmates and receipts from industrial undertakings are grouped together in the last few years of the period. These two categories of income together accounted for a large proportion of total receipts, and about the same proportion at the beginning and end of the period—between 47 per cent and 48 per cent.

The Annual Charities Register notes that this group 'comprises a class of institutions with the most diverse aims with regard to social and physical improvement in its widest sense, the majority being of comparatively recent institution.' It also notes that 'A certain number of the managing boards of undertakings included under this classification in the "Register" do not admit that their institutions may be defined as "Charities," and it is not possible therefore to obtain details of their income.'

#### PROTECTION

This group of charities had an income of about £600,000 in 1928—4 per cent. of the income of all charities. Income

had risen from £337,000 in 1908, an increase of 79 per cent., very similar to the increase for all charities

Charitable contributions rose from £160,000 in 1908 to £272,000 in 1927—an increase of 70 per cent. They were between about 45 per cent and  $47\frac{1}{2}$  per cent of total receipts at both dates. Interest in 1927 was 13 per cent and payments for inmates only 3 per cent of total receipts

Legacies were extremely important, representing 35 per cent of total receipts in 1908 and 37 per cent in 1927. The figure of £221,000 for 1927 was about  $15\frac{1}{2}$  per cent of legacies to all charities, and it will be seen from Table 4 that as a receiver of legacies this group was exceeded in importance only by the Medical, etc., group and Homes for the Young (The figure for 1927 was unusually large, but this group received a large amount in legacies in most years)

The 'Protection' group includes many varieties of charities dealing with the protection of life and the protection of the helpless. The number of institutions included is small—only 27 in 1908 and 17 in 1925-26, but some of them are national societies with large incomes. Three very important societies in this group are the Royal National Lifeboat Institution (income 1934 £310,000), the National Society for the Prevention of Cruelty to Children (income 1934-35 £131,000), and the Royal Society for the Prevention of Cruelty to Animals (income 1934 £135,000)

#### SPIRITUAL INSTITUTIONS

As was noted above, institutions doing religious work are not included in the total figures for the income of charities, unless they combine spiritual work and material relief, when they are classified according to their relief functions. However, the Annual Charities Register gives particulars of the total income of spiritual institutions from 1908 to 1925-26, though not of the sources of that income, nor of the number of institutions included

The total receipts of spiritual institutions rose from £2,530,000 in 1908 to £3,648,000 in 1925-26—an increase of 44 per cent. This increase was considerably smaller both than the increase of total receipts for all other charities (77 per cent) and than the increase in the price level (75 per cent.).

The 'real income' of this group fell by 18 per cent. Nevertheless at the end of the period it was still a large sum as compared with the income of other groups of charities. In 1925-26 the group had a larger total income than any other single group of charities, and a much larger income than any except the Medical, etc., group, whose income was £3,566,000. If the income of spiritual institutions had been included in the total figures for 1925-26 it would have increased them from £14,832,000 to £18,480,000—an increase of 25 per cent.

This group includes some national organizations of religious denominations and also denominational or undenominational societies for religious work at home or overseas, the great majority of these being national (or international). Each of the following societies has an income of over £1 million: the Association for the Propagation of the Faith (Catholic) (income 1934 £712,000), the Church Missionary Society (income 1933-34 £456,000), the British and Foreign Bible Society (income 1934-35 £367,000), the London Missionary Society (income 1933-34 £345,000), and the Society for the Propagation of the Gospel in Foreign Parts (income 1934 £295,000).

#### GENERAL SUMMARY AND CONCLUSIONS

The following points seem to me to be particularly interesting conclusions from the figures dealt with in this chapter.

(1) The remarkable steadiness of the figures over the period. The period 1908 to 1927 included the Great War, the post-War boom and depression, large increases of taxation, the coming of State schemes of health and unemployment insurance and of old age pensions, and a great change in policy with regard to domiciliary poor relief. All these happenings might have been expected to produce great changes in the amount given in charity and in the objects of that charity. Yet the changes have been relatively small. The total 'real income' of the charities covered was about the same at the end as at the beginning of the period, and the tendency on the whole was a steady rise of money income, lagging behind the rise of prices. The same tendency is true of charitable contributions, though, in their case, the rise was less than the rise in prices. There

was also a remarkable steadiness in the distribution of charity between different groups of charities—the Medical, etc., group, Homes for the Young, General Relief, and Social and Physical Improvement were still by far the most important receivers of charitable contributions, in the order given.

(2) The assumption often made that the increase in the State social services has led to a decrease in the amount given in charity does not seem to me to be supported by these figures, though it may be true in the case of some particular forms of charity. It does not seem to be true even in some cases where one would most expect it, e.g. in 'The New Philanthropy' Miss Macadam says 'One is tempted to speculate as to the reasons why homes and orphanages still survive in such large numbers and often on such a large scale. The social services now provide pensions for widows and children, unemployment benefit for the unemployed and their dependents, and other services which make the preservation of home life more possible. In the last quarter of a century domiciliary poor relief has become more generous and institutions for children have greatly improved. Yet with all these improved amenities this particular form of charity persists.' It not only persists but attracted a considerably larger proportion of total charitable contributions at the end than at the beginning of the period.

Another assumption often made, namely, that charitable gifts in general and legacies in particular have been very adversely affected by the increases of taxation, does not seem to be supported by these figures. There was no tendency for the amount given in legacies to these charities to fall over the period as a whole, in fact, there was a rise, though not sufficient to balance the increase in the price level.

(3) There has been a considerable change in the relative importance of the different sources of income of charities. On the average they depend somewhat less than they did on charitable contributions and considerably more on both interest and payments by or for persons to whom the services of the charity are rendered. This change has been particularly marked in some groups of charities. Those of the groups discussed above which show large increases in the proportions of interest are Homes for the Aged and Pensions; General

Relief, Benevolent Institutions, and Social and Physical Improvement Those which show large increases in the proportions of payments for inmates are the Medical, etc, group; Convalescent Homes, Blind, Homes for the Aged and Pensions

## CHAPTER VIII

### CHARITIES IN LIVERPOOL 1907-1933

#### SCOPE OF THE FIGURES

This chapter is based mainly on the figures collected by the Liverpool Council of Social Service (formerly the Liverpool Council of Voluntary Aid) and published by it annually in what is now the 'Liverpool Quarterly'. The Council has had exceptional opportunities for collecting information from the charities in its area because, since 1918, it has administered a charities fund from which it makes grants to most Liverpool charities. Every charity receiving a grant must send to the Council its annual report and statement of accounts, and the Council has endeavoured to get these accounts classified on a uniform basis by supplying a form of accounts prepared by a committee of local accountants. The main part of the central charities fund is allotted to the various charities on the basis of a percentage of their annual subscriptions, and therefore the amount of subscriptions is a point on which information is given in the figures.

Since 1923 figures have been given, for Liverpool charities divided into six groups, of total income, total expenditure, annual subscriptions, income from investments, and total legacies. Figures of total capital have also been given for a rather smaller number of charities. Figures of total income were first given in 1922, but the basis of classification was changed somewhat between 1922 and 1923, so that it seems best to base this account on the period 1923-1933, with some mention of earlier figures. The Annual Report of the Council for 1934 gives some account of the history of the finance of Liverpool charities as part of its description of the work of the Council in the 25 years since its foundation in 1909.

With regard to two classes of income—annual subscriptions and legacies—the Liverpool Council has published figures

for a considerable period before 1923, and these figures will be used in the following description. Reference will also be made to some figures for the amount of subscriptions and donations in 1908. These figures were quoted in a later publication from a special report (not now available) published by the Council in 1910. Another set of figures available is a table of receipts of Liverpool charities in 1907, prepared by the Charity Organization Society and published in an appendix to the documents of the Poor Law Commission of 1905-09, and these figures will also be used. This table gives figures only for the total of all charities, with no sub-division into groups.

The Liverpool Council's published figures give information as to certain classes of income only—annual subscriptions, interest, and legacies. I was anxious to have some information on the other sources of income of Liverpool charities, and I therefore made an analysis and summary from the statements of accounts of individual charities in the hands of the Council. This summary, which is for the year 1929, is also used in the following description. The classification of receipts which it gives must be taken as only very roughly accurate, as it would have been necessary to make a detailed examination of the accounts of every individual charity in order to obtain a uniform classification. For example, the figures given for 'public grants' may include some grants made by bodies other than public authorities, and, in the 'Health Hospitals, etc.' group some receipts are probably included under charitable gifts which should rightly be classed as payments for services rendered.

The Liverpool figures do not include charities dependent entirely on endowments, nor do they include societies engaged solely in religious or temperance work. Unlike the London figures, which, as was explained in the previous chapter, cover much charity that is not London charity, the Liverpool figures (with very few exceptions) cover Liverpool charities only, though some classes of charity probably receive considerable support from districts adjacent to Liverpool. The amount contributed by Liverpool residents to national charities is not included unless it is contributed through a local branch of the charity (as, for example, is the case with



the Liverpool Branch of the Royal Society for the Prevention of Cruelty to Animals)

The tables and descriptions in this chapter are arranged so as to be comparable, as far as possible, with those in the previous chapter

### RECEIPTS OF ALL GROUPS OF CHARITIES

Table 1 shows the receipts for the total of all groups of charities for the years 1923-33. There was a continuous

TABLE 1

RECEIPTS OF ALL GROUPS OF CHARITIES IN LIVERPOOL FOR THE YEARS  
1923-1933

(Figures are given correct to the nearest £100)

	Number of Charities	Total Income.	Annual Subscrip- tions	Interest	Total Legacies
		£	£	£	£
1923	113	783,600	64,000	127,700	101,800
1924	115	790,900	66,300	131,100	80,600
1925	117	771,200	67,500	135,500	50,800
1926	121	794,900	68,200	139,700	48,700
1927	128	949,100	69,600	142,700	120,500
1928	128	891,300	64,300	148,100	335,000
1929	136	938,300	61,700	166,200	153,300
1930	140	971,200	61,300	170,400	107,400
1931	141	905,000	57,100	173,100	98,000
1932	138	871,300	52,900	171,900	61,400
1933	145	895,200	52,600	161,700	132,900

increase in the number of charities for which figures are given (except between 1927 and 1928) from 113 to 145. To some extent this increase is due to the starting of new societies, but in the main it is due to the increasing inclusiveness of

the figures (In nearly all the figures in the following description amounts are given correct to the nearest £100)

Table 2 shows the proportionate changes from year to year, calculated as index numbers with the receipts for 1923 as 100. It also shows the index numbers of 'real income'

TABLE 2

INDEX NUMBERS FOR CERTAIN CLASSES OF RECEIPTS OF ALL GROUPS OF CHARITIES IN LIVERPOOL FOR THE YEARS 1923-1933 (1923=100)

A = Money Income

B = 'Real Income' corrected for Changes in the Cost of Living.

	A MONEY INCOME			Cost of Living (1923 = 100)	B 'REAL INCOME'		
	Total Income	Annual Subscriptions	Total Legacies		Total Income	Annual Subscriptions	Total Legacies
1923	100	100	100	100	100	100	100
1924	101	104	79	100	101	104	79
1925	98	105	50	101	97	104	49
1926	101	107	48	99	102	108	48
1927	121	109	117	96	126	113	122
1928	114	100	328	95	120	105	344
1929	120	96	150	94	127	102	139
1930	124	96	105	91	136	105	115
1931	116	89	96	85	137	106	114
1932	111	83	60	82	135	100	73
1933	114	82	130	80	143	103	163

when allowance has been made for changes in the cost of living. (For caution as to use of these figures see page 174)

#### TOTAL RECEIPTS

The figures of 'total income' from 1923 to 1933 include, besides all ordinary income, free legacies used for revenue purposes. This is the sense in which the term 'total income' will be used throughout this account. The term 'total receipts' will be used to denote receipts including all legacies.

Total income rose from £783,600 in 1923 to £895,200 in 1933, an increase of more than £100,000 and of 14 per cent. The figures do not show at all a uniform increase from year to year—there was a peak of £949,100 in 1927 and another peak of £971,200 in 1930, when total income was 24 per cent. above the 1923 level, there was then a considerable drop until 1932 and a slight recovery between 1932 and 1933.

Thus the economic depression which started in 1929 seems to have had an effect on the figures, but a delayed one. When we turn from money income to real income we find that the charities have benefited much by the fall of a fifth in the price level over the period. Their real income rose by over 40 per cent and was even greater in 1933 than in 1930.

It is interesting also to make a comparison between the Poor Law Commission figures for 1907 and the figures for 1929, though it is impossible to tell to what extent the two sets of figures cover exactly the same ground. Total receipts, including legacies, rose during this period from £315,400 to £1,031,800, an increase of 228 per cent. The rise in the cost of living between the two dates was 75 per cent, so that the rise in the real income of the charities was 87 per cent. If legacies are excluded the figures are £296,200 for 1907 and £878,500 for 1929, making the increase between the two dates 196 per cent in money income and 69 per cent in real income.

It may be noted that the total income of Liverpool charities amounts to more than £1 per head of the population. In 1931 the population of Liverpool was 856,000 and the total income of charities was £905,000.

#### PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME

Table 3 shows the proportions of total receipts received in different classes of income in 1907 and 1929. It also shows the proportions if legacies are treated as 'extraordinary income' and subtracted from the receipts. ('Sundries,' not included in the table, account for under 1 per cent. of total receipts in 1907 and between 1 per cent. and 2 per cent. in 1929.) On the second basis of classification the general results of the comparison are a drop of 22 per cent. in the proportion of charitable contributions, a small rise in interest, and a rise of 17 per cent. in payments for services rendered. If legacies are included, the change in the proportionate importance of charitable gifts and payments for services rendered is not so marked, as the importance of legacies was much greater in 1929 than in 1907 :

on this basis of classification charitable gifts and payments for services rendered bore exactly the same proportion as each other to total receipts in 1929 (41 per cent)

If this table is compared with the similar table for London (page 95) it will be seen that the rise of the proportion of interest is smaller in Liverpool than in London, and that the

TABLE 3

PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME IN ALL GROUPS OF CHARITIES IN LIVERPOOL, 1907 AND 1929

	Total Receipts.		Receipts excluding Legacies.	
	1907	1929	1907.	1929.
	%	%	%	%
Charitable Contributions	48	25	51	29
Legacies . . . . .	6	16	..	..
<i>Total Charitable Gifts .</i>	<i>54</i>	<i>41</i>	<i>51</i>	<i>29</i>
<i>Interest</i>	<i>15</i>	<i>16</i>	<i>16</i>	<i>19</i>
<i>Total Payments for Services Rendered . . .</i>	<i>30</i>	<i>41</i>	<i>32</i>	<i>49</i>

rise in the proportion of payments for services rendered, with the concomitant fall in the proportion of charitable gifts, is much greater. That is to say, the nature of the changes is the same in Liverpool as in London, but there are considerable differences in the magnitude of the changes.

The following pages summarize the information with regard to the different classes of income in 1907-8 and 1929 and from 1923 to 1933.

## CHARITABLE CONTRIBUTIONS

The total amount of charitable contributions (including all charitable gifts except legacies) is given as £152,300 for 1907 in the figures supplied to the Poor Law Commission. In the report on charitable effort in Liverpool made by the Liverpool Council of Social Service for 1908 the total amount of subscriptions and donations for 357 charities is given as £166,000. The total amount of charitable contributions in 1929 was £251,000. The figures for these three dates probably do not cover exactly the same ground, but, taking them as they stand, we find an increase of 65 per cent. between 1907 and 1929 and an increase of 51 per cent. between 1908 and 1929. The increase in the cost of living between 1907 and 1929 was 75 per cent. and between 1908 and 1929 72 per cent., so that in neither case was the increase in charitable contributions equal to the rise in prices, and the 'real income' which they represented was smaller.

The £251,000 received in charitable contributions in 1929 was divided into £61,800 in annual subscriptions and £189,200 in donations, collections, and special efforts. Annual subscriptions amounted to 7.2 per cent. of total receipts excluding legacies, and donations, collections, and special efforts amounted to 22.1 per cent. Thus it will be seen that only about one quarter of the total of charitable contributions was raised in annual subscriptions. Total charitable contributions amounted to about 6s. per head of the population.

The Liverpool Council has published information about annual subscriptions from 1915 onwards. It will be seen from Tables 1 and 2 that over the period 1923-33 the amount of annual subscriptions increased every year from £64,000 in 1923 to a peak of £69,600 in 1927, and then decreased every year to £52,600 in 1933. In 1927 the amount was 9 per cent. above the 1923 level; in 1933 it was 18 per cent. below it. The fall in the cost of living over the period served to counter-balance the fall in the amount of subscriptions, and thus the real income represented by them was slightly higher in 1933 than ten years earlier. The proportion of total income represented by annual subscriptions fell from 8.2 per cent. at the

beginning of the period to 5.9 per cent at the end, its highest point being 8.8 per cent in 1925.

The figures for annual subscriptions in the years 1915-23 are given in the table below. It will be seen from this Table and from Table 1 that the amount of annual subscriptions had been rising every year since 1919, so that the period of continuous increase was from 1919-27.

	Number of Charities	Amount £	Index Number (1923=100)	Index Number of 'Real Income' (1923=100)
1915	125	51,200	80	113
1916	124	51,200	80	95
1917	108	49,300	77	76
1918	110	56,300	88	76
1919	115	51,600	81	66
1920	119	56,600	88	62
1921	116	60,800	95	73
1922	115	62,800	98	94
1923	113	64,000	100	100

#### LEGACIES

The amount of legacies given in the figures for 1907 was £19,200.

The Liverpool Council has published information about legacies from 1914 onwards, but from 1914 to 1921 the figures were not so inclusive as from 1922 onwards. It will be seen from Tables 1 and 2 that over the period 1923-33 total legacies varied between £48,700 in 1926 and £335,000 in 1928. The average annual amount for the eleven years is £117,300 and there is no particular trend discernible. (The amount for 1929 on which the percentage figure in Table 3 is calculated was about 40 per cent. higher than this average.)

## INTEREST

The amount of income from interest given in the 1907 figures was about £47,000 in 1929 it had risen to about £166,000, an increase of 251 per cent. Allowing for the change in the price level between the two dates the increase in real income was 100 per cent. Interest represented 19 per cent of total receipts excluding legacies in 1929 as compared with 16 per cent in 1907.

Table 1 shows the figures for income from interest over the period 1923-33. The figures show a steady rise from 1923 to 1931 and then a fall in each of the succeeding years. The amount for 1931 was 35 per cent above the 1923 level, the amount for 1933 26 per cent above it. The increase in real income over the period was 58 per cent. The proportion of total income represented by income from interest varied between 15.1 per cent and 19.7 per cent in different years of the period.

The Liverpool Council includes in its published information figures for the total capital of charities. These figures, in most years, cover a rather smaller number of charities than the figures of income. The figures are affected by the fact that the number of charities covered rose from 111 in 1923 to 145 in 1933, and that there was an increase in the number of charities giving details of investments. Taking the figures as they stand, they show an increase of total capital from £1,846,400 in 1923 to £2,732,700 in 1933, an increase of 48 per cent. Presumably much of this increase of capital is the result of the investment of legacies and we can compare this figure of £886,300 increase with the figure of £1,188,600 of total legacies in the years 1924-33.

## PAYMENTS FOR SERVICES RENDERED

In 1907 the total payments for services rendered were £96,100 in 1929 they had risen to £422,400, an increase of 339 per cent. If the rise in the cost of living is taken into account the increase in real income is 151 per cent.

The 1907 figures divide payments for services rendered into £45,800 payments by or for inmates and £50,300 industrial receipts. In my analysis of the figures for 1929 I took

the categories of public grants, which accounted for £114,200, and other payments for services rendered, which accounted for £308,200 (I am doubtful whether the figure for public grants is quite accurate. It may include some grants which are not public grants, and on the other side, in six cases some grants were included with donations and collections. In some cases public grants are not separated from other payments for services rendered.) Taking the figure as it stands, out of the 49 per cent of total receipts excluding legacies, shown in Table 3 as accounted for by payments for services rendered, public grants accounted for 13 per cent and other payments for services rendered for 36 per cent.

### RECEIPTS OF VARIOUS GROUPS OF CHARITIES

Table 4 shows the proportions of different classes of income in various years going to the six groups into which the

TABLE 4

PROPORTION OF RECEIPTS OF ALL CHARITIES IN LIVERPOOL GOING TO THE DIFFERENT GROUPS OF CHARITIES IN VARIOUS YEARS FROM 1914 TO 1933

	Total Income		Annual Subscriptions			Legacies	
	1923	1933	1915	1923	1933	1914-18	1929-33
	%	%	%	%	%	%	%
Health Hospitals, etc	39.8	40.1	45.2	44.1	33.7	49.9	39.7
Health - Permanent Infirmity	21.1	23.8	6.6	8.9	9.3	12.3	4.7
Poverty : Temporary . . .	5.1	1.6	6.6	4.5	5.9	4.3	1.4
Poverty : Homes and Pensions	24.4	18.5	24.4	25.0	22.6	30.7	38.5
Moral Infirmity .	2.8	2.4	5.1	3.5	4.7	0.1	0.8
Social Welfare .	6.6	13.5	12.2	14.1	23.8	2.8	14.7



charities are divided. As in London, the Hospitals, etc., group is the most important in all years, but in the period 1914-33 its proportionate importance as a receiver of annual subscriptions and legacies declined considerably. The Social Welfare group increased largely in importance over the period. In this group a considerable number of new organizations have been started recently.

If we compare the proportionate importance of the groups with regard to the three classes of receipts shown in the table, we find that the most striking points are (a) that the Health Permanent Infirmary group is much more important with regard to total income than with regard to either annual subscriptions or legacies, (b) that the Poverty Homes and Pensions group is favoured with legacies in comparison with annual subscriptions, while in the Social Welfare group this position is reversed.

The following pages give a summary of the position over the period of the charities in each of the six groups into which they are classified.

#### HEALTH HOSPITALS, ETC

Most of the charities in this group are hospitals, but it includes also dispensaries, convalescent homes, district nursing associations, and various other medical charities.

The total income of this group rose from £300,900 in 1923 to £359,500 in 1933, an increase of 19 per cent in money income and 49 per cent in real income. The number of charities included was 28 in 1923 and 34 in 1933. The peak of income was £394,200 in 1930.

The figure of £121,000 in charitable contributions, excluding legacies, had increased from £54,600 in subscriptions and donations in 1908, an increase of 122 per cent. Annual subscriptions increased (not quite steadily) from £22,600 in 1915 to the peak of £31,000 in 1925 and 1926, and then decreased (again not quite steadily) to £17,700 in 1933—22 per cent below the 1915 level. Whereas in 1925 and 1926 annual subscriptions accounted for over 10 per cent. of total income, in 1933 they accounted for under 5 per cent.

In the years 1923-33 legacies varied between £18,800 and

£67,500 with an average of £42,500. There was no marked trend over the period.

My analysis for 1929 shows the following amounts and proportions of total receipts in different forms of income

<i>Total Receipts</i>	£ 397,200	%
Annual Subscriptions	23,000	5.8
Donations, Collections and Special Efforts	98,300	24.8
Total Legacies	49,000	12.3
<i>Total Charitable Gifts</i>	<i>170,300</i>	<i>42.8</i>
<i>Interest</i>	<i>47,400</i>	<i>11.9</i>
Public Grants	48,200	12.1
Other Payments for Services Rendered	123,100	31.0
<i>Total Payments for Services Rendered</i>	<i>171,300</i>	<i>43.1</i>
(Sundries)	8,100	2.0

Interest rose almost every year from £42,700 in 1923 to £48,900 in 1931 and then fell sharply to £39,900 in 1933. Capital increased from £883,700 in 1923 to £1,127,600 in 1933.

Several of the charities in this group have large incomes. Five hospitals had, in 1929, total receipts of over £30,000—the Royal Infirmary, the Royal Southern Hospital, the Royal Liverpool Children's Hospital, the David Lewis Northern Hospital, and the Consumption Hospital.

#### HEALTH PERMANENT INFIRMITY

This group includes institutions and other organizations for the care of the blind, deaf and dumb, crippled, and mentally infirm. The total income of the group rose from £151,800 in 1923 to £213,000 in 1933—an increase of 40 per cent in money income and 75 per cent in real income. The peak of income was £218,800 in 1929. The number of charities included was 11 in 1923 and 13 in all the other years of this period.

The figures for 1929 show the following amounts and proportions of total receipts in different forms of income :

<i>Total Receipts</i>	<i>£</i> <i>227,600</i>	<i>%</i>
Annual Subscriptions . . .	5,800	2 5
Donations, Collections, and Special Efforts . . .	1,600	0 7
Total Legacies . . .	9,600	4 2
<i>Total Charitable Gifts</i> . . .	<i>17,000</i>	<i>7 5</i>
<i>Interest</i> . . .	<i>21,800</i>	<i>9 6</i>
Public Grants . . .	49,400	21 7
Other Payments for Services Rendered . . .	138,400	60 8
<i>Total Payments for Services Rendered</i> . . .	<i>187,800</i>	<i>82 5</i>
(Sundries . . .)	1,100	( 0 5)

The figure of £7,400 in charitable contributions, excluding legacies, had decreased from £10,504 in subscriptions and donations in 1908, a decrease of 29 per cent. Annual subscriptions, after considerable variation in the years 1915-19, increased steadily to between £5,700 and £5,850 in all the six years 1924-29, they then decreased steadily to £4,900 in 1933.

Legacies, in the years 1923-33, varied between £800 and £9,600, with an average of £5,200 and no marked trend over the period.

Interest rose from £18,000 in 1923 to a peak of £21,800 in 1929 and then decreased to £20,600 in 1933. The amount of capital increased from £331,700 in 1923 to £404,900 in 1933.

The most striking point about the finance of this group is the very large proportion of income—over 80 per cent—in payments for services rendered. A large proportion of the amount entered as public grants is in grants to societies for the blind under the Blind Persons Act, 1920. (Probably a certain proportion of the amount classified as other payments for services rendered is in payments from public authorities.)

Two of the institutions in this group have incomes of over

£30,000—The Royal Albert Institution, Lancaster (for mental defectives), of whose cases only about one twelfth come from Liverpool, and the Liverpool Workshops and Home Teaching Society for the Outdoor Blind

#### POVERTY TEMPORARY

This group includes societies giving temporary help to the general population in money or in particular forms of relief (e.g. clothing), and societies aiding particular sections (e.g. the Jewish community)

(In considering the changes in the total income of the group from 1923–33, I have taken into account the fact that one of the societies—the Central Relief Society—which ceased to exist independently after 1932, collected amounts of about £24,000 to £28,000 a year in subscriptions and donations for other societies. These amounts are included in the Liverpool Council's figures for total incomes up to 1930, and as they seriously affect the total figures for the group I have deducted the amount for 1923 from the figure given below and for purposes of the proportions in Table 4, and the amount for 1929 from the 1929 figures below and from the figures in Table 3. In the other figures in this chapter these amounts are not deducted.)

The total income of the group fell from £38,900 in 1923 to £14,100 in 1933, a decrease of 64 per cent. in money income and 55 per cent. in real income. The number of charities included was 13 in 1923 and 12 in 1933.

Annual subscriptions were £3,300 in 1915 and £3,100 in 1933. They had dropped to £1,900 in 1931 and increased considerably during the last two years. Whereas in 1923 they were only 7.4 per cent. of total income, in 1933 they were 21.9 per cent., more than three times as large a proportion as for all charities. Other charitable contributions were a large proportion of income.

The figure for total legacies in 1929 was considerably higher than the average for the period 1923–33, which was £1,700. During this period legacies varied between £350 and £4,250.

Interest increased from £1,100 in 1923 to £1,400 in 1933. It represented only a small proportion of total income.

The figures for 1929 show the following amounts and proportions of total receipts in different forms of income.

<i>Total Receipts</i>	<i>£</i> <i>28,300</i>	<i>%</i>
Annual Subscriptions	2,800	9.7
Donations, Collections, and Special Efforts	18,100	64.0
Total Legacies	3,200	11.3
Total Charitable Gifts	24,100	84.9
Interest	1,500	5.5
Public Grants	200	0.6
Other Payments for Services Rendered	2,000	7.1
Total Payments for Services Rendered	2,200	7.7
(Sundries)	500	1.9

Payments for services rendered were of very little importance in this group of charities.

Excluding the amounts collected by the Central Relief Society on behalf of other organizations, none of the charities in this group had incomes of more than £8,000 in 1929.

#### POVERTY HOMES AND PENSIONS

This group includes homes for children, homes for the aged, pensions societies, and benevolent societies.

The total income of the group showed considerable variation over the period 1923-33. In 1923 it was £185,300: in 1933 it was £165,800. This was a decrease of 11 per cent. in money income and an increase of 12 per cent. in real income. The figure for 1933 was the lowest during the period. The highest figure was £254,900 in 1927—this was much higher than the figure for any other year, the nearest approach being £198,000 in 1930. The number of charities included was 21 in 1923 and 1933, 19 in 1926, and 20 in all the other years of the period.

The figures for 1929 show the following amounts and proportions of total receipts in different forms of income.

<i>Total Receipts</i>	£ 217,800 0	%
Annual Subscriptions	16,000	7 4
Donations, Collections, and Special Efforts	42,600	19 5
Total Legacies	47,000	21 6
<i>Total Charitable Gifts</i>	105,600	48 4
<i>Interest</i>	80,800	37 1
Public Grants	9,600	4 4
Other Payments for Services Rendered	21,200	9 7
<i>Total Payments for Services Rendered</i>	30,800	14 2
(Sundries)	600	0 3)

The figure of £58,600 in charitable contributions, excluding legacies, had risen from £42,200 in subscriptions and donations in 1908—an increase of 39 per cent. Annual subscriptions were at about the same level in 1915 (£12,200) and 1933 (£11,900). They reached their highest point at £16,600 in 1925 and from £16,000 in 1929 they decreased each year.

Legacies represented a considerable proportion of total receipts in 1929, and the figure for that year—£47,000—was below the average for the years 1923–33, which was £55,200. In 1928 the group received £246,800 in legacies.

Interest represented a very large proportion of total receipts—37 per cent as compared with 16 per cent for the total of all the groups. The amount of interest increased steadily from £60,000 in 1923 to £85,600 in 1931 and then decreased to £84,900 in 1933. The amount of capital increased almost every year from £500,000 in 1923 to £870,800 in 1933.

As a correlative to the exceptionally large proportion of total receipts represented by interest and legacies, the proportion represented by payments for services rendered was only 14 per cent as compared with 41 per cent for all charities.

Three of the charities in this group had, in 1929, total

receipts of over £30,000—the Mercantile Marine Service Association Charities, the Royal Liverpool Seamen's Orphan Institution, and the Liverpool Merchants' Guild

#### MORAL INFIRMITY

This group includes societies engaged in 'rescue work' and in providing homes for unmarried mothers and their babies, and societies engaged in police court mission work and work with discharged prisoners

The total income of the group is a very small proportion of the income of all Liverpool charities. It rose from £20,900 in 1923 to £25,900 in 1929 and then fell to £21,700 in 1933. The 1933 figure represented an increase of 4 per cent in money income and 30 per cent in real income over the 1923 figure. The number of charities included rose from 10 in 1923 to 15 in 1933.

The figures for 1929 show the following amounts and proportions of total receipts in different forms of income:

<i>Total Receipts</i>	<i>£</i> <i>26,600</i>	<i>%</i>
Annual Subscriptions	2,300	8 8
Donations, Collections, and Special Efforts	7,100	26 9
Total Legacies	2,700	10 0
<i>Total Charitable Gifts</i>	<i>12,100</i>	<i>45 7</i>
Interest	900	3 6
Public Grants	5,000	19 0
Other Payments for Services Rendered	8,100	30 6
<i>Total Payments for Services Rendered</i>	<i>13,100</i>	<i>49 5</i>
(Sundries)	300	1 2)

The figure of £9,500 in charitable contributions, excluding legacies, had risen from £4,600 in subscriptions and donations in 1908—an increase of 104 per cent. Annual subscriptions amounted to about £2,500 in both 1915 and 1933 and there was no marked trend over the period. They represented a

somewhat higher proportion of total income than in the total of all groups

The 1929 figure for legacies was very much higher than the average for the period 1923-33, which was only £1,100, and represented only a small proportion of total receipts

Interest increased from £600 in 1923 to £950 in 1931 and then decreased to £850 in 1933. It represented a very small proportion of total receipts—3½ per cent in 1929 compared with 16 per cent for all charities. Capital increased from £13,500 to £24,400 in the period 1923-33.

None of the charities in this group had, in 1929, incomes of more than £4,000

#### SOCIAL WELFARE

This group comprises a considerable variety of societies, including recreational organizations for young people, settlements and community councils, societies concerned with the protection of human and animal life, as well as a number of societies with other objects

The total income of the group rose from £49,600 in 1923 to £121,100 in 1933, an increase of 144 per cent in money income and 205 per cent in real income. The large growth of total income is partly accounted for by the increase of number of charities included from 29 in 1923 to 50 in 1933. (In 1932, when 44 charities were included, the total income was £95,100.)

The figure of £33,400 in charitable contributions, excluding legacies, had risen from £16,900 in subscriptions and donations in 1908, an increase of 98 per cent. Annual subscriptions rose from £6,100 in 1915 to their highest point of £12,500 in 1933. In 1933 they represented 10.3 per cent of total income as compared with 5.9 per cent for all charities. In earlier years they had been even more important proportionately: in 1925 they represented 19.3 per cent.

As was mentioned above, legacies averaged £11,600 over the period 1923-33, varying in different years between £3,100 and £41,800 (the figure for 1929).

Interest increased almost every year from £5,200 in 1923 to £15,000 in 1932 and then fell to £14,000 in 1933. Capital increased from £91,600 in 1923 to £292,900 in 1933.



The figures for 1929 (when 43 charities were included) show the following amounts and proportions of total receipts in different forms of income (in the case of this group the figure for legacies in 1929 happens to be both a large absolute amount and nearly four times as high as the average figure for the period 1923-53, so I have substituted the latter figure)

<i>Total Receipts</i> . . . . .	£ 78,400	%
Annual Subscriptions .	11,900	15 2
Donations, Collections, and Special Efforts	21,500	27 4
Total Legacies	11,600	14 8
<i>Total Charitable Gifts</i> .	45,000	57 4
<i>Interest</i> .	13,300	16 9
Public Grants .	1,900	2 4
Other Payments for Services Rendered	15,400	19 6
<i>Total Payments for Services Rendered</i>	17,200	22 0
(Sundries . . . . .)	3,000	3 8)

The proportion of total income received in payments for services rendered was only about half the proportion for all charities—22 per cent as against 41 per cent. The proportion received in public grants was especially small.

None of the charities included in this group in 1929 had incomes, exclusive of legacies, of more than £7,000

### GENERAL SUMMARY AND CONCLUSIONS

(1) There seems little doubt that, on the whole, Liverpool charities improved their position in the years 1923-33. Total income increased, though there was a setback in 1931-32, capital increased, and the charities benefited considerably by the fall in the price level. They had also greatly increased their total receipts as compared with the position in 1907, and the increase since that date was much greater than the rise in the price level.

(2) There seems also little doubt that this improvement in the position of the charities was not due mainly to an increase in ordinary charitable contributions. These do not seem to have increased in the period between 1908 and 1929 sufficient to balance the rise in prices, and the proportion of total receipts which they represent had fallen greatly. Annual subscriptions, which amount to only about a quarter of charitable contributions, had decreased by more than a quarter since 1927 and were in 1933 below the level of ten years earlier, though this fall had been offset by the fall in prices. They accounted at the end of the period for only about 6 per cent of total income. The very small financial importance of the annual subscriber is one of the most striking conclusions from the figures, and contrasts markedly with his importance in the management and control of many charities. The remarks just made about ordinary charitable contributions do not apply to legacies, which have shown no tendency to decrease. As a considerable number of legacies are devoted to capital purposes this fact helps to account for the increase of capital during the period and the increasing proportion of income from interest. But the main reason for the increase of total receipts between 1907 and 1929, and presumably also between 1923 and 1933 (though here I have no figures with which to support the contention) was the large increase in the amount received in payments for services rendered. To a much larger extent than formerly those benefiting from the services rendered by charities are paying some part of the cost and public authorities are also paying much more on their behalf. Charity proper is now often engaged in subsidizing a service rather than paying for it in full.

(3) With regard to the distribution of total receipts between the different groups of charities, the Social Welfare group has greatly increased its proportion of total income in the period 1923-33, while the two Poverty groups have considerably decreased their proportions. In annual subscriptions the Social Welfare group has largely increased and the Hospitals group has largely decreased its proportion. As between the averages of the years 1914-18 and 1929-33 both the Health groups have decreased considerably in their

proportions of total legacies, and the Social Welfare and Homes and Pensions groups have increased considerably. But, despite these changes in relative importance, the Hospitals group is still by far the most important in respect to both total receipts and ordinary charitable contributions (excluding legacies).

## CHAPTER IX

### VOLUNTARY HOSPITALS IN ENGLAND AND WALES 1924-1934

#### SCOPE OF THE FIGURES

THERE is little doubt that (if religious organizations are excluded) the voluntary hospitals receive the largest total income of any group of charities. It is therefore very fortunate that for this group of charities there exist figures covering not one locality only but the whole country.

This chapter is based on two sources of information. The first source is the annual 'Hospitals Year Book,' published by the Central Bureau of Hospital Information under the auspices of the Joint Council of the Order of St. John and the British Red Cross Society, and the British Hospitals Association, and edited by Mr. R. H. P. Orde. This year-book has been published annually since 1931 and was preceded by an annual publication 'The Voluntary Hospitals in Great Britain.' The 1928 issue of the latter and the issues of the former from 1931 to 1935 have been used for this chapter. 'The Voluntary Hospitals in Great Britain' included information as to all hospitals in Great Britain except London. The 'Hospitals Year Book' includes London also, the figures for London being based on the statistics collected by the King Edward's Hospital Fund. (As my summary is confined to England and Wales, the figures for Scotland and Ireland, also given in the 'Hospitals Year Book,' are not included.)

The second source of information for this chapter is the 'Statistical Review of the Work and Finance of the London Voluntary Hospitals,' published annually by the King Edward's Hospital Fund for London. (The Review for 1936—covering the 1935 figures—which was published after this chapter was written, contains comparative statistics for the whole period 1921-35.)

The area covered by the King Edward's Hospital Fund for London and, therefore, included in their figures, is the area falling within 11 miles of St Paul's Cathedral, including the whole of the County of London and in addition parts of Essex, Hertfordshire, Kent, Middlesex, and Surrey. Hospitals in this area are termed 'London hospitals' in this chapter; hospitals in the rest of England and Wales are termed 'provincial hospitals'.

Within the two groups of London and provincial hospitals the statistics are assembled on a uniform classification, but the two groups do not use exactly the same categories of classification as each other. For this reason it has been necessary, in most of this chapter, to treat the two groups separately, but it is possible to deal with the total figures for England and Wales in certain broad categories and these figures are first dealt with.

The figures include a very large proportion of all the voluntary hospitals. In 1934 they cover between 97 per cent. and 98 per cent. of the total available beds. The provincial figures include the receipts of convalescent homes which are conducted as departments of hospitals, while the London figures do not include these; neither set of figures includes independent convalescent homes. The figures do not include mental hospitals nor tuberculosis sanatoria.

## FIGURES FOR ALL HOSPITALS IN ENGLAND AND WALES

### TOTAL RECEIPTS 1924-1934

Table 1 gives the figures of total receipts of all hospitals in England and Wales for the period 1924 to 1934. (It is based for the years 1931 to 1934 on the figures in the 'Hospitals Year Book,' and for the years 1924 to 1930 on a combination of the figures in the 'Hospitals Year Book' for the provincial hospitals and the figures in the King Edward's Fund Statistical Review for the London hospitals.) The figures for Total Ordinary Income exclude all legacies. The figures for Total Receipts include, besides total ordinary income, legacies, both free and ear-marked, and receipts for capital purposes, besides some other receipts. The Table

shows, besides the actual amounts, the proportionate changes from year to year, given as index numbers with 1924 as the base, and the proportionate changes in 'real income' when allowance has been made for changes in the cost of living. (For caution as to use of these figures see page 174)

The number of hospitals included in the figures rose from 798 to 854 during the period, an increase of 7 per cent.

Total ordinary income rose from about £71 million in 1924 to about £106 million in 1934. This was an increase of

TABLE 1

TOTAL ORDINARY INCOME AND TOTAL RECEIPTS, 1924-1934, OF THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES

(Actual amounts and index numbers, with 1924=100, of money income and of 'real income' corrected for changes in the cost of living)

	NUMBER OF HOSPITALS	TOTAL ORDINARY INCOME			TOTAL RECEIPTS			COST OF LIVING (1924 = 100)
		Amount £000s	Index Number		Amount £000s	Index Number		
			Money Income	' Real Income '		Money Income	' Real Income '	
1924	798	7,126	100	100	9,814	100	100	100
1925	792	7,612	107	106	10,718	109	108	101
1926	796	7,562	106	108	10,422	106	108	98
1927	797	8,142	114	119	11,369	118	123	96
1928	806	8,556	120	126	12,121	123	130	95
1929	807	8,832	124	132	12,632	129	137	94
1930	821	9,419	132	146	13,260	135	150	90
1931	820	9,377	132	156	12,510	127	151	84
1932	826	9,826	138	169	13,101	133	163	82
1933	829	10,053	141	177	13,163	137	172	80
1934	854	10,642	149	185	14,262	145	180	81

49 per cent in money income and of 85 per cent in real income. These figures show, as was shown by the figures for Liverpool charities, during roughly the same period, that charities benefited very much by the fall of about 20 per cent. in the cost of living during this decade. There were increases in total ordinary income in every year except 1926 and 1931, when there were slight falls.

Total receipts rose from about £98 million in 1924 to about £14½ million in 1934—an increase of 45 per cent in money income and 81 per cent in real income, slightly smaller proportionate increases than those for total ordinary income.

Here also there were increases in every year except 1926 and 1931, when there were falls

#### CLASSES OF RECEIPTS, 1931-1934

Table 2 shows the main categories of receipts of all hospitals in England and Wales for the years 1931-34 and Table 3 shows the proportionate importance of each category

TABLE 2

CLASSES OF RECEIPTS OF VOLUNTARY HOSPITALS IN ENGLAND AND WALES, 1931-1934

	Receipts £000s			
	1931	1932	1933	1934
<i>Total Charitable Contributions</i>	2,929	3,059	3,004	3,087
<i>Income from Investments</i>	1,568	1,606	1,516	1,558
<i>Total Receipts for Services Rendered</i>	4,758	5,036	5,400	5,873
<i>Other Receipts</i>	122	125	133	125
TOTAL ORDINARY INCOME	9,377	9,826	10,053	10,642
Free Legacies	1,229	1,149	1,317	1,154
Ear-marked Legacies	296	270	540	572
<i>Total Legacies</i>	1,525	1,419	1,857	1,726
<i>Other Receipts outside Ordinary Income</i>	1,608	1,859	1,552	1,895
TOTAL RECEIPTS OUTSIDE ORDINARY INCOME	3,133	3,278	3,409	3,621
TOTAL RECEIPTS	12,510	13,104	13,463	14,262
Number of Hospitals Included	820	826	829	854

at the beginning and end of that period. (Tables 2 and 3 are based on the figures in the Hospitals Year Book.)

It will be seen that total ordinary income increased by about £1½ million during these four years. Of this increase only about £150,000 was in charitable contributions, while the rest was in payments for services rendered. Charitable contributions dropped from 31 per cent. to 29 per cent. of ordinary income and payments for services rendered rose from 51 per cent. to 55 per cent. Income from investments

fluctuated during these years and was about the same amount at the beginning and end of the period. Its proportion of ordinary income dropped from 16·7 per cent. to 14·6 per cent. The total amount of invested funds possessed by the hospitals rose from £31·4 million in 1931 to £33·8 million in 1934.

A striking feature of hospital finance is the large amount of receipts outside ordinary income. At both the beginning

TABLE 3

PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME IN THE VOLUNTARY HOSPITALS IN ENGLAND AND WALES, 1931 AND 1934

	Proportion of Total Ordinary Income		Proportion of Total Receipts.	
	1931 %	1934 %	1931 %	1934 %
<i>Total Charitable Contributions</i>	31·3	29·0	23·4	21·7
<i>Income from Investments</i>	16·7	14·6	12·5	10·9
<i>Total Receipts for Services Rendered</i>	50·8	55·2	38·1	41·2
<i>Other Receipts</i>	1·3	1·2	1·0	0·9
<b>TOTAL ORDINARY INCOME</b>	<b>100·0</b>	<b>100·0</b>	<b>75·0</b>	<b>74·6</b>
<i>Free Legacies</i>			9·8	8·1
<i>Ear-marked Legacies</i>			2·4	4·0
<i>Total Legacies</i>			12·2	12·1
<i>Other Receipts outside Ordinary Income</i>			12·9	13·3
<b>TOTAL RECEIPTS OUTSIDE ORDINARY INCOME</b>			<b>25·1</b>	<b>25·4</b>
<b>TOTAL RECEIPTS</b>			<b>100·0</b>	<b>100·0</b>

and end of the period about 25 per cent. of total receipts were in receipts outside ordinary income—about 12 per cent. in legacies and about 13 per cent. in other receipts. The actual amount of legacies varied between £1·4 million and £1·9 million during these years. In every year at least two thirds of the amount was in free legacies. The amount of other receipts outside ordinary income varied between £1·5 million and £1·9 million. These other receipts are nearly all charitable gifts for capital purposes, so that practically



the whole amount of receipts outside ordinary income, amounting to £3 1 million in 1931 and £3 6 million in 1934, is in charitable gifts. If these amounts are added to the amounts of charitable contributions falling under ordinary income we get totals for all charitable gifts of £6 1 million in 1931 (48·5 per cent of total receipts) and £6 7 million in 1934 (47·1 per cent of total receipts). Thus it is fairly safe to say that in recent years the total annual charitable gifts to voluntary hospitals have been between six and seven million pounds, and a little under half of their total receipts.

#### FIGURES FOR LONDON HOSPITALS, 1927-34

Table 4 shows the total receipts and the categories of receipts of London hospitals in the period 1927-34. Table 5 shows the proportionate importance of each category of receipts at the beginning and end of that period. These tables are based on the figures in the King Edward's Fund Statistical Review. (They cover a rather smaller number of hospitals than the London figures in the Hospitals Year Book used in Tables 2 and 3 and in the years 1931-34 in Table 1.) The figures do not include receipts for Special Funds, that is, funds for objects outside the general purposes of the hospital. In each year of publication the Statistical Review gives figures for the same number of hospitals over the last five years, this system gives an opportunity of comparing receipts over a number of years without the complication which usually exists of a change in the number of institutions included. I have taken advantage of this fact by arranging the figures for the eight years in two groups, the first group 1927-30, covering 142 hospitals, and the second group 1930-34, covering 145 hospitals. The overlapping year 1930 shows the differences caused by the variation in the number of hospitals (though some differences are also caused by adjustments of the figures on the basis of later information received).

(For the figures for London hospitals in the period 1908 to 1927 reference should be made to the section on 'Relief in sickness and medical and surgical aid' in Chapter VII above. It will be noted that the figures from the Annual Charities Register given there for 1927 roughly correspond



to the King Edward's Fund figures for the same year. The differences are due partly to the fact that the figures in Chapter VII include certain other kinds of medical charities in addition

TABLE 5

PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME IN THE LONDON VOLUNTARY HOSPITALS, 1927 AND 1934

	Proportion of Total Ordinary Income		Proportion of Total Receipts	
	1927	1934	1927	1934
	%	%	%	%
Subscriptions, Donations, etc	31.8	27.3	21.2	20.0
Central Funds	9.8	9.2	6.6	6.8
Total Charitable Contributions	41.5	36.5	27.7	26.8
Income from Investments	20.4	18.2	13.6	13.3
Receipts from Patients and their Societies	28.1	35.7	18.7	26.2
Receipts from Public Authorities	8.3	7.8	5.5	5.7
Total Receipts for Services Rendered	36.4	43.6	24.3	32.0
Fees and Other Receipts	1.7	1.8	1.1	1.3
TOTAL ORDINARY INCOME	100.0	100.0	66.8	73.5
Free Legacies			7.6	7.9
Capital Receipts for Endowments			4.3	2.9
Capital Receipts for Buildings and Equipment			21.1	15.8
Other Receipts outside Ordinary Income			0.2	0.0
TOTAL RECEIPTS OUTSIDE ORDINARY INCOME			33.2	26.6
TOTAL RECEIPTS			100.0	100.0

to hospitals. It is also probable that the Annual Charities Register figures, while including all ordinary income and legacies, have not full information about receipts for capital purposes other than legacies.)

## TOTAL RECEIPTS

Total ordinary income rose from £2.9 million in 1927 to £3.6 million in 1934—an increase of £650,000 and 22 per cent.

It increased every year except 1931, when there was a slight decrease. Total receipts rose from £4.4 million in 1927 to £4.9 million in 1934—an increase of £500,000 and 11 per cent. Receipts outside ordinary income were smaller in amount in 1934 than in 1927 and represented only 27 per cent instead of 33 per cent of total receipts.

#### CHARITABLE GIFTS

The London figures show five categories of charitable gifts. Under ordinary income there are subscriptions, donations, etc., and central funds. Under other receipts there are free legacies, capital receipts for endowment, and capital receipts for buildings and equipment.

The total of all these categories of charitable gifts was rather lower in 1934 than in 1927. In 1927 it was £2,672,000—60.7 per cent of all receipts, in 1934 it was £2,612,000—53.4 per cent of all receipts. The decrease in the actual amount was due to decreases in capital receipts both for endowments and for buildings and equipment. These figures include both ear-marked legacies and other gifts for capital purposes, and there is no distinction made in the figures between legacies and other gifts. Capital receipts for endowments were about £190,000 in 1927 and about £140,000 in 1934. They varied greatly over the period, between about £100,000 in 1933 and about £240,000 in 1930. Capital receipts for buildings and equipment varied still more. Their amount of £930,000 in 1927 was their maximum during the period, from 1928 to 1930 they were between £800,000 and £900,000, in 1931 they dropped by almost 50 per cent to about £450,000, in 1932 and 1933 they were between £300,000 and £350,000, and in 1934 they more than doubled their amount to about £770,000. The Statistical Review comments that 'the general depression, which became accentuated in 1931 and 1932 and showed no signs of lifting until the latter part of 1933, no doubt caused some Hospitals to defer their appeals for building schemes' and that 'this slowing down of extensions and improvements and of the provision of up-to-date medical and surgical equipment has been, perhaps, the most serious result of the financial stringency'.

Free legacies amounted to £333,000 in 1927 and £385,000

in 1934—between  $7\frac{1}{2}$  per cent and 8 per cent of total receipts at both dates. They varied over the period between £254,000 in 1928 and £509,000 in 1933.

The amounts of charitable contributions falling under ordinary income were much steadier from year to year than the charitable gifts outside ordinary income. These charitable contributions increased from £1·2 million to £1·3 million over the period—an increase of 7 per cent. They represented  $36\frac{1}{2}$  per cent of ordinary income at the end of the period as compared with  $41\frac{1}{2}$  per cent at the beginning.

'Subscriptions, donations, etc.,' which include all charitable contributions except those given through central funds, increased from £933,000 in 1927 to £980,000 in 1934—an increase of 5 per cent. Their proportion of ordinary income fell from 31·8 per cent to 27·3 per cent. The highest amount for the period was £1,077,000 in 1928 and in both 1929 and 1930 also the figure was over £1 million. (In 1930 there was an exceptionally large single donation of £100,000.) In the four years 1931-34 the amount was between about £970,000 and about £990,000. Thus since 1928 there has been no upward trend and for the last four years the amount has remained at about the same level.

The amount received from central funds rose from £288,000 in 1927 to £332,000 in 1934—an increase of 15 per cent. It represented between 9 per cent and 10 per cent of ordinary income at both dates. The amount rose steadily from 1927 to the peak of £344,000 in 1932 and 1933 and then fell to 1934. The most important central fund is the King Edward's Hospital Fund for London, which exists to obtain effective support for the voluntary hospitals of London, and which, in 1933 and 1934 made grants of £300,000 to the income and capital accounts of London hospitals and convalescent homes (also £20,000 to hospitals towards superannuation expenditure). Another central fund is the Metropolitan Hospital Sunday Fund which arranges for a collection on a fixed Sunday in each year in the places of worship in London for distribution among London medical charities. In 1933 and 1934 its income from collections was about £24,000. It also received donations and legacies.

## INCOME FROM INVESTMENTS

Income from investments rose from £600,000 in 1927 to £652,000 in 1934—an increase of 9 per cent. Its proportion of total ordinary income fell from 20·4 per cent to 18·2 per cent. The amount rose every year until 1932, when it reached a peak of £663,000; it then fell to £640,000 in 1933 and rose again to £652,000 in 1934.

## RECEIPTS FOR SERVICES RENDERED

In the tables in the Statistical Review the figures for 'Fees and other Receipts,' which have been classified separately in the tables in this chapter, are included with receipts for services rendered. I have excluded them in order to make the London figures comparable with the provincial figures, which do not include them. As will be seen from Tables 4 and 5, they account for a comparatively small amount of income, and therefore there is no need to discuss them further.

When these figures are excluded, the tables show that the amount of total receipts for services rendered rose steadily from £1,069,000 in 1927 to £1,564,000 in 1934—an increase of 46 per cent. Their proportion of total ordinary income increased from 36·4 per cent to 43·6 per cent.

Receipts for services rendered are divided into the two categories of receipts from public authorities and payments from patients and their societies. Receipts from public authorities rose from £244,000 in 1927 to £281,000 in 1934—an increase of 15 per cent. Their proportion of total ordinary income fell from 8½ per cent to 7½ per cent. They increased every year after 1928.

Payments from patients and their societies rose from £825,000 in 1927 to £1,283,000 in 1934—an increase of 56 per cent. Their proportion of total ordinary income rose from 28 per cent to 35½ per cent. They increased every year during the period. This increase is the most striking feature of the finance of the London hospitals during this period. The figures do not allow a distinction to be made between payments by individual patients, payments from Approved Societies as 'additional benefits' under the National Health Insurance Scheme, and payments from hospital contributory associations and the Hospital Saturday Fund: all these types of payments, as well as some others, are included in this

TABLE 6  
CLASSES OF RECEIPTS OF PROVINCIAL VOLUNTARY HOSPITALS 1924-1934

	RECEIPTS £000S											
	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933-	1934	
Subscriptions	638	667	665	691	673	675	690	668	649	651	669	
Donations (including Entertainments, etc )	719	833	794	898	849	812	830	803	870	843	895	
Congregational Collections	167	165	165	163	162	162	146	134	118	117	114	
Total Charitable Contributions	1524	1665	1624	1752	1684	1649	1666	1604	1637	1611	1678	
Income from Investments	711	722	745	754	800	828	873	900	912	858	888	
Patients' Contributions	644	672	724	778	836	905	1065	1143	1232	1394	1595	
Women's Contributions, Hospital Saturday Funds, and Contributory Schemes	1249	1341	1264	1471	1607	1738	1804	1712	1813	1871	2054	
Public Services	379	354	360	395	386	393	552	550	559	617	617	
Total Receipts for Services Rendered	2272	2367	2348	2644	2829	3036	3421	3405	3604	3882	4266	
Other Receipts	44	56	46	52	45	45	56	56	56	65	57	
TOTAL ORDINARY INCOME	4551	4811	4763	5203	5359	5557	6016	5965	6210	6416	6888	
Free Legacies	454	483	511	749	792	658	617	713	743	751	720	
Ear-marked Legacies	122	100	132	64	162	118	177	136	176	457	475	
Total Legacies	576	582	644	813	955	775	794	849	919	1208	1195	
Other Receipts Outside Ordinary Income	1069	1236	1168	1153	1370	1567	1558	1095	993	1194	1036	
TOTAL RECEIPTS OUTSIDE ORDINARY INCOME	1645	1818	1812	1966	2325	2342	2332	1944	1912	2402	2231	
TOTAL RECEIPTS	6196	6629	6575	7169	7684	7900	8348	7909	8122	8819	9119	
Number of Hospitals Included	662	654	656	655	661	662	676	667	668	671	697	

category of receipts. The most important hospital contributory association is the Hospital Saving Association, which has about 90 per cent of its contributors in London. The receipts of London voluntary hospitals from this Association increased yearly from about £250,000 in 1930 to about £400,000 in 1934, in which year it had 1,366,000 contributors.

### FIGURES FOR PROVINCIAL HOSPITALS, 1924-34

Table 6 shows the total receipts and the categories of receipts of provincial hospitals in the period 1924-34. Table 7 shows the proportionate importance of each category of

TABLE 7

PROPORTION RECEIVED IN DIFFERENT CLASSES OF INCOME IN THE PROVINCIAL VOLUNTARY HOSPITALS, 1924 AND 1934

	Proportion of Total Ordinary Income		Proportion of Total Receipts	
	1924	1934	1924	1934
	%	%	%	%
Subscriptions	14.0	9.7	10.3	7.3
Donations (including Entertainments, etc.)	15.8	13.0	11.6	9.8
Congregational Collections	3.7	1.7	2.7	1.3
<i>Total Charitable Contributions</i>	<i>33.5</i>	<i>24.4</i>	<i>24.6</i>	<i>18.4</i>
<i>Income from Investments</i>	<i>15.6</i>	<i>12.9</i>	<i>11.5</i>	<i>9.7</i>
Patients' Contributions	14.2	23.1	10.4	17.5
Workmen's Contributions, Hospital Saturday Funds, and Contributory Schemes	27.5	29.9	20.2	22.5
Public Services	8.3	9.0	6.1	6.8
<i>Total Receipts for Services Rendered</i>	<i>49.9</i>	<i>61.9</i>	<i>36.6</i>	<i>46.8</i>
<i>Other Receipts</i>	<i>1.0</i>	<i>0.8</i>	<i>0.7</i>	<i>0.6</i>
<b>TOTAL ORDINARY INCOME</b>	<b>100.0</b>	<b>100.0</b>	<b>73.5</b>	<b>73.5</b>
Free Legacies		.	7.3	7.8
Ear-marked Legacies		.	2.0	3.2
<i>Total Legacies</i>		.	<i>9.3</i>	<i>11.1</i>
<i>Other Receipts outside Ordinary Income</i>		.	<i>17.3</i>	<i>11.4</i>
<b>TOTAL RECEIPTS OUTSIDE ORDINARY INCOME</b>		.	<b>26.5</b>	<b>24.4</b>
<b>TOTAL RECEIPTS</b>	<b>..</b>	<b>..</b>	<b>100.0</b>	<b>100.0</b>



receipts at the beginning and end of that period. These figures are based on the tables in the Hospitals Year Book and its predecessor 'The Voluntary Hospitals in Great Britain'.

#### TOTAL RECEIPTS

Total ordinary income rose from £4.55 million in 1924 to £6.9 million in 1934—an increase of £2.3 million and 51 per cent. It increased every year except 1926 and 1931, when there were slight decreases. Total receipts rose from £6.2 million in 1924 to £9.1 million in 1934—an increase of £2.9 million and 47 per cent. They increased every year except 1926 and 1931. Receipts outside ordinary income represented 26½ per cent of total receipts in 1934 and 24½ per cent in 1934.

The number of hospitals included in the figures rose from 662 in 1924 to 697 in 1934—an increase of 5 per cent. The number included decreased in 1925, 1927, and 1931, and rose every other year.

#### CHARITABLE GIFTS

The provincial figures show six categories of charitable gifts. Under ordinary income there are subscriptions, donations, and congregational collections. Under receipts outside ordinary income there are free legacies, ear-marked legacies, and other receipts outside ordinary income. (The Hospitals Year Book classifies the first three categories given above and also the category of workmen's contributions, Hospital Saturday Funds, and contributory schemes as 'voluntary gifts', but I have included this latter category under receipts for services rendered, both because many of its receipts are in the nature of voluntary insurance contributions and in order to make the provincial figures comparable with the London figures.)

The total of all these categories of charitable gifts rose from £3.17 million to £3.9 million between 1924 and 1934, but its proportion of total receipts decreased from 51.1 per cent to 42.8 per cent.

Total legacies were £576,000 (9.3 per cent of total receipts) in 1924, and rose to £1,195,000 (13.1 per cent of total receipts)

in 1934. Legacies increased every year from £576,000 in 1924 to £955,000 in 1928, then dropped to £775,000 in 1929 and then increased every year to £1,208,000 in 1933. Up to 1933 only a quarter or less of total legacies were in the form of ear-marked legacies and their amount was never more than £200,000, but in both 1933 and 1934 ear-marked legacies increased to between about £450,000 and £475,000. Free legacies were very steady in amount in the last four years of the period, varying only between £713,000 and £751,000. It should be noted that the distinction between free and ear-marked legacies is confused by the fact that some hospitals credit free legacies direct to special funds.

The category 'Other receipts outside ordinary income' consists almost entirely of charitable gifts for capital purposes, other than legacies. The amount in this category was almost the same at the end as at the beginning of the period—about £1.05 million. This amount represented 17.3 per cent of total receipts in 1924 and 11.4 per cent in 1934. The amount varied over the period between about £990,000 in 1932 and about £1.55 million in 1929 and 1930; there was a drop of nearly £450,000 between 1930 and 1931.

The total amount of charitable contributions falling under ordinary income rose from £1.5 million to £1.7 million during the period—an increase of 10 per cent. They represented 33.5 per cent of ordinary income in 1924 and only 24.4 per cent in 1934.

Subscriptions varied over the period between £638,000 in 1924 and about £690,000 in 1927 and 1930; they showed no marked tendency to either rise or fall. They represented 14 per cent of ordinary income in 1924 and 9½ per cent in 1934.

The category of 'donations, including entertainments, etc.' varied in amount up and down from year to year but there was a rising tendency over the period. The average annual amount in 1924–27 was about £810,000 and in 1931–34 about £850,000—an increase of 5 per cent. They represented 15½ per cent of ordinary income in 1924 and 13 per cent in 1934.

Congregational collections, on the other hand, showed a steady annual decrease from £167,000 in 1924 to £114,000 in

1934—a fall of 32 per cent Their proportion of ordinary income fell from  $3\frac{3}{4}$  per cent to  $1\frac{3}{4}$  per cent

#### INCOME FROM INVESTMENTS

Income from investments rose from £711,000 in 1924 to £888,000 in 1934—an increase of 25 per cent Its proportion of total ordinary income fell from  $15\frac{1}{2}$  per cent to 13 per cent An increase in amount occurred every year between 1924 and 1932, when the peak of £912,000 was reached

#### RECEIPTS FOR SERVICES RENDERED

The provincial figures show three categories of receipts for services rendered—public services, workmen's contributions, etc., and patients' contributions The total receipts in these three categories rose from £2 27 million in 1924 to £4 27 million in 1934—an increase of 88 per cent They represented 62 per cent of total ordinary income at the end of the period as compared with 50 per cent at the beginning

The category of 'public services' includes not only receipts from public authorities but also receipts from Approved Societies under the National Health Insurance Scheme (It is therefore not strictly comparable with the category 'Receipts from public authorities' in the London figures) The amount in this category rose from £379,000 in 1924 to £617,000 in 1934—an increase of 63 per cent It represented 9 per cent of ordinary income in 1934 as compared with  $8\frac{1}{4}$  per cent in 1924 The amount rose every year during the period except 1925, 1928 and 1931 'The Voluntary Hospitals in Great Britain' gave details of the sources of these receipts in the period 1924-28 During that period the provincial hospitals received an average annual amount of £106,000 from Approved Societies, £94,000 for work in connection with venereal diseases, £42,000 for infant welfare and maternity work, £33,000 for work in connection with tuberculosis, £22,000 from the Ministry of Pensions, and £18,000 from Education Authorities (besides various other payments) With regard to payments from Approved Societies under the National Health Insurance Scheme the Ministry of Health Report for 1934-35 gives the following amounts as expended in 'Hospital treatment benefit' in

the last ten years (The figures cover the whole of England including London, but they do not include Wales.)

	£		£
1925	217,000	1930	207,000
1926 .	227,000	1931 .	161,000
1927 .	223,000	1932	111,000
1928 .	159,000	1933	104,000
1929 .	199,000	1934	88,000

The Report suggests with regard to the fall in the amounts since 1930 'It is thought that this result may be due among other causes to the increase during recent years of voluntary contributory schemes for the provision of hospital treatment.' In the schemes for additional benefits in force from January 1935 there are in England 2,336 schemes covering about 7½ million members which make provision for hospital treatment benefit, and the annual amount allocated is £159,000

The amount of receipts in the category of workmen's contributions, Hospital Saturday Funds, and contributory schemes rose from £1 25 million in 1924 to £2 05 million in 1934—an increase of 64 per cent. The amount represented 27½ per cent of ordinary income in 1924 and 30 per cent in 1934. It increased every year except in 1926 and 1931. Some of the schemes which contribute to this category of receipts have large memberships of contributors, for example, the Birmingham Hospitals Contributory Association with (in 1934) 470,000 contributors, the Merseyside Hospitals Council with 290,000, the Sheffield and District Association of Hospital Contributors with 250,000, the Leicester and County Hospital Society with 135,000, the Norwich Hospitals Contributory Scheme with 120,000, the Swansea General and Eye Hospital Contributory Scheme with 115,000, and the Wolverhampton Royal Hospital Contributory Scheme with 105,000. As most contributory schemes benefit the dependants of contributors as well as the contributors themselves the numbers benefiting by these schemes are considerably larger than those given.

The third category of receipts for services rendered is that of payments from individual patients. The amount of these payments rose from £644,000 in 1924 to £1,595,000 in 1934—

an increase of 148 per cent. This proportionate increase over the period was much greater than that of any other category of receipts. The amount represented 14 per cent. of ordinary income in 1924 and 23 per cent. in 1934. Patients' payments increased in amount every year throughout the period.

### GENERAL SUMMARY AND CONCLUSIONS

(1) In 1934 the voluntary hospitals in England and Wales had total receipts of about £14½ million, of which about three quarters was received in ordinary income. Charitable gifts of all kinds amounted to about £6½ million—47 per cent. of total receipts. About £3 million of this amount was in charitable contributions to ordinary income; the rest was in legacies and other contributions for capital purposes and the importance of these latter types of charitable gifts is very striking.

(2) Two important contrasts appear between the London and provincial figures for 1934. (a) The proportion of total receipts received in charitable gifts is much larger in London than in the provinces (53 per cent. as compared with 43 per cent.). The proportion received in interest is also higher. (b) The proportion of total receipts received in payments for services rendered is much larger in the provinces than in London (47 per cent. as compared with 32 per cent.).

(3) Over the decade 1924–34 the receipts of the voluntary hospitals in England and Wales rose between 40 per cent. and 50 per cent. in actual amount and the hospitals also benefited by the fall of about 20 per cent. in the cost of living. (The depression of 1931 had a considerable adverse effect on capital receipts but hardly affected ordinary income.) The financial troubles of the voluntary hospitals as a whole have certainly not been caused by any fall in income.

(4) In both London and the provinces the most striking change with regard to receipts in the last few years has been the large increase in payments for services rendered—an increase of 57 per cent. between 1927 and 1934 over the whole of England and Wales. The provincial figures show that, while there was a large increase in payments from contributory schemes, etc., there was a much larger increase in payments from individual patients.

## CHAPTER X

### OTHER INFORMATION ON CHARITIES AND CHARITABLE RECEIPTS

#### CHARITIES AND CHARITABLE RECEIPTS INCLUDED IN THE TOTAL ESTIMATES FOR ENGLAND AND WALES

##### RECENT ESTIMATES OF THE TOTAL NUMBER OF CHARITIES IN ENGLAND AND WALES

THE Home Office Departmental Committee on the Supervision of Charities, which published its Report in 1927, was set up 'To consider and report whether any form of supervision is desirable over collecting charities (that is to say, charities which seek financial help from the public) and if so to make recommendations in the matter' The Committee was not concerned with endowed charities (where the estimate of 80,000 was given for those under the supervision of the Charity Commissioners), except in cases where a charity was both an endowed charity and a collecting charity

With regard to collecting charities the law requires registration of only two types of charities—war charities, under the War Charities Act, 1916, and charities for the blind, under the Blind Persons Act, 1920 Under the War Charities Act a total number of 11,950 charities had been registered in England and Wales up to September 1926, and a further 6,531 charities had been exempted as too small to need registration Most of these charities had ceased to exist at the time of the investigations of the Departmental Committee (in London, for example, only about one seventh of those registered remained in operation) The number of charities for the blind which had been registered in England and Wales up to September 1926 was 252

For information regarding the total number of collecting charities the Departmental Committee was dependent on

the informed guesses of various witnesses, and, owing to the limited amount of statistical information available, there was considerable divergency between these guesses

The Annual Charities Register and Digest, published by the Charity Organization Society, gave some 2,500 separate entries of charities (endowed and unendowed) either situated in or available for London. On the analogy of the proportion between war charities in London and the whole country this would give some 32,250 reputable established charities throughout England and Wales, and the Committee states that 'This figure may fairly be taken as a minimum on a conservative basis'. If small and temporary collections for special objects are included the Committee thinks that the total number of collecting charities much exceeds even the 80,000 estimated as the number of endowed charities. On the other hand one witness from the Charity Organization Society estimated 15,000 to 16,000 as about the number of established charities in the whole country—'But it is all guesswork', he added, and the same conclusion is given in the statement of the Committee that 'One of the chief difficulties which we have experienced in this enquiry has been the impossibility of obtaining reliable figures, or even a trustworthy estimate, of the number of charities which fall within its scope'.

#### RECEIPTS OF DISTRICT NURSING ASSOCIATIONS IN ENGLAND AND WALES IN 1934

For information as to the finance of district nursing reference should be made to Section III of this book, particularly Chapter XVII. Below is the summary of the figures for 1934 from the Queen's Institute 'Survey of District Nursing in England and Wales'. These figures are given in more detail in Chapter XVII. They cover returns from 3,169 Associations employing 5,106 nurses. (The total number of nurses employed by Associations at that date was 7,285, so that the financial figures cover Associations employing 70 per cent of the nurses.)

In the classification of sources of income interest is not classified separately but is included with 'Other Sources'. Legacies are not mentioned separately. The Survey notes that 'The totals received from provident subscriptions are

underestimated as in many instances they were classified in the local annual reports under voluntary subscriptions and cannot, therefore, be given separately'

RECEIPTS OF DISTRICT NURSING ASSOCIATIONS 1934	Amount £000s	Proportion of Total Income. %
Total Income	1060	100
Voluntary Subscriptions and Dona- tions	265	25
Special Efforts	91	9
Local and Other Charities	25	2
<i>Total Charitable Gifts</i>	<i>380</i>	<i>36</i>
Patients' Payments	163	15
Provident Subscriptions	253	24
Public Grants	181	17
<i>Total Payments for Services Rendered</i>	<i>597</i>	<i>56</i>
<i>Other Sources</i>	<i>82</i>	<i>8</i>

RECEIPTS OF CHARITIES FOR THE BLIND IN LONDON,  
1924-32

Under the Blind Persons Act, 1920, charities for the blind which collect from the public must be registered with the council of the County or County Borough in which they are situated, and must furnish annual returns to that council. The volumes of 'London Statistics' published annually by the London County Council have given figures of the receipts of all blind charities registered with the Council since the year 1924-25. The figures for 1924-25 and 1932-33 are given in the following Table they should be compared with the C O S figures for London given in Chapter VII, page 103.

It will be seen from the Table that between 1924-25 and 1932-33 the number of charities increased from 31 to 34:



the number includes national societies whose offices are in London as well as London charities. Total income rose from £740,000 to £796,000—an increase of 8 per cent. The proportion of total income received from interest was about 10½ per cent in both years, the proportion received from public grants rose from 6 per cent. to 17 per cent, the proportion from charitable gifts decreased from 76 per cent to 61 per cent. There was a decrease in the actual amount of charitable gifts from £564,000 to £486,000—a decrease of 14 per cent.

Since March 1935 the position of London blind charities has been much affected by the decision of the London County Council to administer most of the services for the welfare of the blind directly instead of through voluntary societies

CHARITIES FOR THE BLIND IN LONDON  
AMOUNT AND PROPORTION RECEIVED IN DIFFERENT CLASSES OF  
INCOME IN 1924-25 AND 1932-33

	Amount £000s		Proportion %	
	1924-5	1932-3	1924-5	1932-3
Subscriptions and Donations	540	282	72.9	35.4
Legacies		179		22.5
Greater London Fund for the Blind		25		3.2
<i>Total Charitable Gifts</i>	564	486	76.2	61.1
<i>Interest</i>	76	84	10.3	10.6
Government Grants	31	3	4.2	0.4
Grants from the London County Council	4	91	0.6	11.4
Grants from other Local Authorities	8	40	1.0	5.1
<i>Total Public Grants</i>	43	134	5.8	16.8
Fees for Training and Maintenance	57	72	7.7	9.1
Receipts from other London Charities for the Blind		7		0.9
Other Income		13		1.6
<i>Total Other Receipts</i>	57	92	7.7	11.5
<b>TOTAL INCOME</b>	<b>740</b>	<b>796</b>	<b>100.0</b>	<b>100.0</b>
<b>Number of Charities . . .</b>	<b>31</b>	<b>34</b>		

## LEGACIES

In Mr Josiah Wedgwood's book 'The Economics of Inheritance' there are two estimates given of the amount of philanthropic legacies and of their proportion to the amount of all legacies

One estimate is with regard to the total number of estates of over £50,000 for which probate was granted in the two months of February and March 1925 (The information is from the lists given in 'The Times' and the author states that it may be taken as very nearly complete)

The gross capital value of these estates was about £16,390,000. The amount bequeathed to charitable institutions and to employees was about £1,330,000—8·1 per cent of the total. But of this sum about two thirds was in the form of reversions, and the author estimates that the present value of the bequests was only about 4 per cent of the total capital value of the estates. The proportion bequeathed to individual employees accounted for only about  $\frac{1}{2}$  per cent, leaving about  $7\frac{1}{2}$  per cent on the first basis of estimate and  $3\frac{1}{2}$  per cent on the second basis as bequeathed to charitable institutions. Of the 115 estates considered charitable bequests were entirely absent or under 1 per cent of the total in 75 cases; on the other hand in 8 cases more than 50 per cent was bequeathed in charity.

Mr Wedgwood's other estimate is based on the official figures for the amount of bequests paying the highest rate of legacy and succession duties. (This rate applies not only to all bequests to charitable institutions, with certain minor exceptions, and to employees, but also to bequests to other persons not related to the testator and to distant relations.)

These figures show that in the average of the three years 1911-14 £16·8 million paid the highest rate of duty—6·6 per cent. of the amount of all unsettled estates over £1,000. In the four years 1922-25 the figure was £25·5 million—6·3 per cent. Thus the proportion has changed very little between these periods. The author comments 'The great increase in taxation in recent years has apparently had little effect in checking the proportion of philanthropic bequests, though several testators refer to it as a deterrent. Differences in temperament,

and the existence or absence of family dependants are obviously 'much more important factors' (Compare the very similar conclusion reached on the London figures in Chapter VII)

#### STREET COLLECTIONS IN THE METROPOLIS, 1924-34

In general collections for charities come under no legal supervision but there are exceptions with regard to certain types of charities and with regard to one particular method of collection—street collections, which include flag days. Under Section V of the Police, Factories, etc (Miscellaneous Provisions) Act of 1916 a police authority may make regulations with respect to places where, and conditions under which, persons may be permitted in any street or public place within the area of its jurisdiction to collect money or sell articles for the benefit of charitable or other purposes.

The Annual Reports of the Commissioner of Police for the Metropolis give the following information for the decade 1924-34 (The amounts are given correct to the nearest £100)

	Number of Collections Authorized	Amount Collected £	Percentage Cost of Collection %
1924	365	189,700	14½
1925	385	212,700	12½
1926	367	239,400	13½
1927	297	225,600	12½
1928	322	249,600	11
1929	321	257,200	12½
1930	318	264,600	12½
1931	288	241,600	12½
1932	288	230,900	11½
1933	263	232,700	12
1934	252	236,000	12½

It will be noted from these figures that the number of collections authorized has declined during the period by 113—31 per cent. The drop of 70 between 1926 and 1927

was principally due to the amended regulations which provided for the holding of collections at stationary positions only. The Report for 1934 states that the Advisory Committee on Street Collections has taken steps to scrutinize the applications for collections more closely, 'having regard to the fact that the frequency of such collections has been the subject of complaint for some years'. In 1934 out of 269 applications 17 were refused and out of the 252 authorized 239 were actually held. But the vast majority of these collections were in very limited areas and only 27 covered the whole or a substantial part of the Metropolitan Police District.

The total amount collected has varied over the period between about £190,000 and £265,000, with an average for the eleven years of about £235,000. The average for the last three years is considerably lower than for the four previous years.

## CHARITIES EXCLUDED FROM THE TOTAL ESTIMATES FOR ENGLAND AND WALES

### ENDOWED CHARITIES

An endowed charity is one in which the capital is settled upon a permanent trust and the income only is applicable to the purpose of the charity. All such charities fall under the jurisdiction of the Board of Education, if they are charities for educational purposes, or of the Charity Commissioners, if they are charities for any other purpose. Many endowed charities have no income except from their endowments and in that case the jurisdiction of the supervisory authorities mentioned covers the whole of their finance. In the case of charities supported partly by endowments and partly by voluntary donations and other current receipts the jurisdiction of the supervisory authorities relates only to their endowments.

Every charity which has endowments must send in its annual accounts to the Charity Commissioners (or to the Board of Education) where they are open to inspection by the public. The Charity Commissioners publish an annual Report, but the information contained in it is of very little use for the purpose of this investigation.

The Report for England and Wales for 1934 states that

for that year the number of separate charities sending in accounts was 51,808 for 1933 the number was 49,220. This number is considerably less than the total of all charities under the jurisdiction of the Commissioners. The estimate given by the Commissioners in 1927 to the Departmental Committee on the Supervision of Charities was approximately 80,000.

No estimate of the amount of income of endowed charities has been published since the information collected for the Poor Law Commission of 1905-09. The only figure of income given in the Report of the Charity Commissioners is that of the aggregate income derived from the stocks, securities and annuities held by the Official Trustees of Charitable Funds—this income amounted to £2,867,000 in 1934. The Official Trustees of Charitable Funds exist for the purpose of holding stocks, shares, securities and moneys affected by charitable trusts, but there is no legal obligation for any endowed charity to make use of their services, so that the above figure covers the income of only those endowed charities who choose to do so. The total amount of capital held by the Official Trustees in 1934 was about £85½ million, divided into 58,650 accounts.

No figures are published as to the total number of educational endowed charities falling under the jurisdiction of the Board of Education. But I am informed by the Board of Education that the total number in England and Wales in 1934 is estimated as something less than 29,000.

#### RECEIPTS OF RELIGIOUS ORGANIZATIONS

As was explained in Chapter VI, the receipts of purely religious charities are excluded from the total estimates given in Chapter XI, although these charities are included both in the legal definition of charities and in the definition which I have adopted throughout this book. Charities for purely religious objects are not concerned with general social services and their activities are not comparable with the social service activities of the State. I consider that an adequate description of the finance of religious organizations would require a special detailed study, and the information given below is merely a very summary account of such information on religious finance as is easily available.

Some information about the finance of religious organizations has already been given in Chapter VII, pages 108-109. The Charity Organization Society's figures for London show that in the year 1925-26 'spiritual institutions' had total receipts of £3,648,000. These receipts had increased from £2,530,000 in 1908—an increase of 44 per cent in money income and a decrease of 18 per cent in 'real income'. These figures include the receipts of several large missionary societies.

In the 'Economic Journal' for March 1931 and for March 1934 Mr A. E. Feavearyear gives estimates of the total annual expenditure on religion in the course of two articles on 'Spending the National Income' and 'The National Expenditure, 1932'. These figures relate to Great Britain and are for the average of the years 1924-27 and the year 1932. They are given in the following table.

	1924-27	1932.
	£ Mn	£ Mn
Established Churches of England and Scotland		
Endowment Income . . . . .	8½	9
Church of England Voluntary Offerings . . . . .	11	10
Other Income of the Established Churches . . . . .	4½	
Other Denominations . . . . .	18	14
Total Expenditure on Religion . . . . .	42	33
Proportion of Total Expenditure on All Purposes . . . . .	1 %	1 %

Mr Feavearyear's figures for the endowment income of the Established Churches of England and Scotland and for voluntary offerings collected by the Church of England are

taken from figures published by those bodies. With regard to other denominations he states 'The endowment income of other denominations is small, but if offertory receipts were in proportion to the number of churches and chapels, their income amounted to about' the figures given.

It is arguable to what extent all voluntary contributions to religious organizations should be regarded as strictly charitable. The contributions of members of religious denominations to their own local congregations might be regarded as contributions to the provision of a common service, and thus more akin to the contributions made to such bodies as clubs, friendly societies, and trade unions than to charitable donations. However, the payments of church members to the funds of their local congregations are rarely equal as between different members, nor are they assessed on a sliding scale according to income, and in fact the richer or more generous members are helping to finance the service for the poorer or less generous members. Contributions made to the national organizations of religious denominations, to religious societies for special purposes, and to home and foreign missionary activities are certainly charitable in nature, as the donor receives no direct benefit from the service to which he contributes.

#### RECEIPTS OF POLITICAL ORGANIZATIONS

In accordance with the definition of charity given in the Introduction to this book I have included contributions and donations to associations for propaganda as charitable gifts, on the ground that these contributions and donations are for purposes which are of no direct economic benefit to the donor.

There is little doubt that the political parties have a larger amount of total receipts than any other type of propaganda associations, except religious organizations. But there is hardly any information available as to the total receipts or expenditure of political parties, either for their general work or for particular purposes. The only kind of expenditure about which there is general information is the expenditure on behalf of candidates at parliamentary elections. In this

case the information is complete, because there is a legal limitation of the amount which may be spent on behalf of any candidate and a return of expenditure must be sent to the Returning Officer by the election agent of each candidate. The Home Office Return of the expenses of candidates at the General Election of 1935 shows that the total expenditure in England and Wales was £651,362.



## CHAPTER XI

### AN ESTIMATE OF THE AMOUNT OF RECEIPTS OF ALL CHARITIES IN ENGLAND AND WALES AND A STATISTICAL AND ECONOMIC COMPARISON WITH PUBLIC SOCIAL SERVICE FINANCE.

#### INTRODUCTION

It will be obvious from what has been said in many parts of this Section that the available information on charitable finance is too scarce and too diversely classified for it to be possible to make any accurate estimates of the total receipts and the main classes of receipts of all charities in England and Wales. However I consider that enough information is available for some statements to be made as to the kind of magnitude of charitable receipts and as to the trends in charitable finance over recent years. It seems to me that even very doubtful estimates are preferable to no estimates, as they will at least serve as a basis for criticism and amendment. But I would emphasize the caution that in all the paragraphs which follow the estimates given have a very large possible margin of error. It is the *kind* of conclusions reached, not the quantitative accuracy of those conclusions, which seems to me to be established by the evidence.

The estimates given for England and Wales cover only organized charities and three types of organized charities are excluded—purely endowed charities, purely religious charities, and organizations for political propaganda. The statements made are based on all the evidence cited in this Section and also on the information with regard to the finance of district nursing given in Section III.

#### ESTIMATE OF THE TOTAL RECEIPTS OF ALL CHARITIES IN ENGLAND AND WALES IN 1934

What is the kind of magnitude of the total annual receipts of all charities in England and Wales? My answer to this

question is that, if the income of purely endowed charities and of purely religious and political organizations is excluded, the total receipts of all charitable organizations in 1934 were probably between £35 million and £50 million.

This figure is based on the two following methods of estimate

(1) The figures for Liverpool given in Chapter VIII show that in 1931 the 'total income' of the Liverpool charities covered by the figures was £905,000. This 'total income' includes all ordinary income and also free legacies used for revenue purposes. It does not include receipts for capital purposes. In 1931 the population of Liverpool was 856,000, so that the income of Liverpool charities in that year amounted to about £1.15 per head of the population. The estimated population of England and Wales in 1934 was 40,500,000. If we assume that the income of charities per head of the population is the same for the whole country as it is for Liverpool, we get a figure of £42,500,000 as the 'total income' of all charities in England and Wales.

How far is this basis of estimate justified?

It should be noted first that the estimate excludes receipts for capital purposes. These receipts consist partly of earmarked legacies and partly of other gifts. They probably fluctuate more from year to year than does the amount of ordinary income received, but they amount on the average to a substantial sum (in the voluntary hospitals alone they amounted to £2.5 million in 1934, but they are probably more important in this class of charities than in charities as a whole).

It should be noted secondly that the figures for Liverpool charities do not include contributions of Liverpool residents to national charitable organizations which have not a branch in Liverpool, nor do the figures include many small or temporary forms of organized charity, and there are various other omissions. For these reasons an estimate based on the Liverpool figures is likely to be too small.

On the other hand there are usually more forms of organized charity in large towns than in small towns and country areas, and among large towns Liverpool is exceptionally well provided with charitable organizations. For these

reasons an estimate based on the Liverpool figures is likely to be too large

(2) There is no doubt that (if religious organizations are excluded) the income of the voluntary hospitals is by far the largest block of income of any form of charity in the country, and fortunately the figures available for hospital incomes are reasonably inclusive. These figures show that in 1934 the voluntary hospitals in England and Wales had a total ordinary income of £10,600,000; total receipts of £14,300,000, and a total 'income available for maintenance' of £11,800,000. It is the figure for this last category which can be used for this estimate. It includes besides all ordinary income free legacies used for revenue purposes, and corresponds to what has been termed 'total income' in the figures for Liverpool charities.

In 1934 the total 'income available for maintenance' of the fifteen Liverpool hospitals included in the total figures of hospital income amounted to £278,400. This income was 32.5 per cent of the 'total income' of all Liverpool charities in that year (about £857,700). If we assume that the comparative financial importance of the voluntary hospitals and of other forms of charitable organizations is the same in the country as a whole as it is in Liverpool, we get a figure of £36,400,000 for the 'total income' of all charities in England and Wales.

How far is this basis of estimate justified? On the one hand the estimate is probably too small in that the figure does not include receipts for capital purposes and in that the figures available for hospital income are much more inclusive than the figures available for other kinds of charitable organizations. On the other hand the estimate is probably too large in that voluntary hospitals are probably of smaller financial importance compared with other kinds of charitable organizations in Liverpool than in the country as a whole. This is due to the fact that there are more other kinds of charitable organizations in large towns than in small towns and country areas, and that Liverpool is exceptionally well provided with charitable organizations. But this conclusion is somewhat modified by the fact that Liverpool hospitals serve, and therefore receive their income from, a somewhat

larger area than Liverpool to a probably greater extent than other kinds of charitable organizations in Liverpool •

There are, unfortunately, no statistics of the income of all charities in any area other than Liverpool. The London figures given in Chapter VII are of no use for this particular purpose because they include both some charities in other places and many national charities. The Cambridge figures given further on in this chapter are not compiled on the same basis and are also fifteen years out of date. It is therefore impossible with the present available information to use any other area as a check with regard to whether the position in Liverpool can be regarded as fairly typical of the position in the country as a whole.

The two bases of estimate described give figures of £42,500,000 and £36,400,000 as the 'total income' of charities in England and Wales, and to either of these figures a substantial sum must be added to arrive at a figure for total receipts. I have given above the other reasons for considering, on the one hand, that the figures are likely to be an under-estimate and, on the other hand, that they are likely to be an over-estimate. On balance I consider that these figures are far more likely to be too low than too high and therefore, in giving my estimate of total receipts as between £35 million and £50 million, I have allowed for a greater possible margin of under-estimate than of over-estimate.

It may be noted that there is actual evidence of a total of £27,000,000 in total receipts of charities. This figure is the sum of the following amounts —voluntary hospitals in 1934, £14,250,000, London charities (excluding hospitals and nursing associations) in 1927, £11,150,000, district nursing associations in 1934, £1,050,000, Liverpool charities (excluding hospitals and nursing associations) in 1929, £600,000.

#### ESTIMATE OF THE AMOUNTS RECEIVED IN DIFFERENT CLASSES OF INCOME BY ALL CHARITIES IN ENGLAND AND WALES IN 1934

What are the annual amounts received in different classes of income by all charities in England and Wales? In considering this question I shall use the estimate already given

for total receipts and combine with it the available information as to the proportionate importance of different classes of income in various groups of charities. With regard to this aspect of charitable finance there are more sources of information than with regard to total receipts, but it must be remembered that an additional source of possible error occurs because of the differences of classification adopted in different cases. The main sources of information available are the London figures given in Chapter VII, the Liverpool figures, the figures for voluntary hospitals, and the figures for district nursing associations given in Chapter XVII in Section III and summarized in Chapter X.

#### CHARITABLE GIFTS

In 1927 (the latest year covered by the figures) the total charitable gifts received by the charities in London included in the C O S figures amounted to £7,562,000—50 per cent. of the total receipts of these charities. Of this amount £6,142,000 was received in 'charitable contributions'—41 per cent. of total receipts, and £1,419,000 was received in legacies—9 per cent. of total receipts. (The category 'charitable contributions' includes all charitable gifts other than legacies.)

Among the nine main groups of charities (listed in the Table on page 100) the highest proportion of total receipts received in charitable gifts was 82 per cent. in the protection group, and the lowest was 42 per cent. in the group covering homes for the aged and pensions. The highest proportion of 'charitable contributions' was 57 per cent. in the group covering homes for the young, and the lowest was 31 per cent. in the group covering homes for the aged and pensions. The highest proportion of legacies was 37 per cent. in the protection group, and the lowest was 3 per cent. in the general relief group. It will be noted that the comparative importance of legacies varies much more between different kinds of charities than does the comparative importance of other forms of charitable gifts. Legacies fluctuate considerably from year to year but the figures for 1927 for all London charities (though not for separate groups) are fairly near to the average for the five years 1922-27.

The Liverpool figures for 1929 show a total of £414,500

received in charitable gifts—41 per cent of total receipts. Of this amount £251,000 was received in 'charitable contributions'—25 per cent of total receipts, and £163,500 was received in legacies—16 per cent of total receipts. In the case of Liverpool the 1929 figure for legacies is much higher than the figure for the average of the years 1923-33 if we substitute this latter figure (and make a corresponding adjustment to the amount of total receipts) we find that the proportion of 'charitable contributions' rises to 26 per cent. of total receipts and that legacies amount to £117,000—12 per cent of total receipts. On this basis the proportion of total charitable gifts is 38 per cent of total receipts.

Among the six groups of charities in which the Liverpool charities are classified (listed in the Table on page 121) in 1929 the highest proportion of total receipts received in charitable gifts was 85 per cent in the temporary poverty group and the lowest proportion was 7 per cent in the permanent infirmity group. The highest proportion of 'charitable contributions' was 74 per cent in the temporary poverty group and the lowest was 3 per cent in the permanent infirmity group. The highest proportion of legacies was 22 per cent in the group 'poverty homes and pensions' and the lowest proportion was 4 per cent in the permanent infirmity group. The range between these two groups would have been even greater if the figure used had been that of average legacies in the years 1923-33.

The figures for voluntary hospitals in England and Wales in 1934 show a total of £6,700,000 received in charitable gifts—47 per cent of total receipts. Of this amount £1,700,000 was received in legacies—12 per cent of total receipts, £3,100,000 was received in charitable contributions to ordinary income—22 per cent of total receipts, and £1,900,000 was received in charitable gifts (other than legacies) for capital purposes—13 per cent of total receipts. Legacies and other charitable gifts for capital purposes fluctuate considerably from year to year, but as it happens, the proportions for 1934 were very similar to those for the three preceding years. The proportion of total charitable gifts to total receipts was considerably higher in London than in the provincial hospitals—53 per cent. compared with 43 per cent.

The figures for district nursing associations in England and Wales in 1934 show a total of £380,000 received in charitable gifts—36 per cent of total receipts. There is no separate figure given for legacies but they probably are of relatively small importance in the finance of district nursing.

My conclusion is that probably about 50 per cent of the total receipts of all charities in England and Wales is received in charitable gifts of all kinds. The difference between the percentages shown in the figures for Liverpool and for London is probably due mainly to the inclusion in the latter figures of many national charities (e.g. the large children's Homes and large societies for protection) where the percentage of charitable gifts is high. I am influenced in the direction of adopting a rather high estimate by the facts that probably many of the available figures do not include extraordinary gifts for special purposes, and that the kind of charities not included in the figures (e.g. small relief organizations), probably have a high proportion of charitable gifts. On the other hand some of the amounts included under charitable contributions are probably in the nature of provident contributions which should be classed under payments for services rendered.

If we apply this estimate of 50 per cent to the estimate of total receipts given above we get a figure of something between £17½ million and £25 million as the total of all charitable gifts to organized charities in England and Wales.

It may be noted that there is actual evidence of a total of £13,100,000 in charitable gifts. This total is the sum of the following amounts: voluntary hospitals in 1934, £6,700,000; London charities (excluding hospitals and nursing associations) in 1927, £5,800,000; district nursing associations in 1934, £380,000; Liverpool charities (excluding hospitals and nursing associations) in 1929, £250,000.

Of the total proportion of 50 per cent of total receipts represented by charitable gifts probably about 10 per cent is received in legacies. This estimate applied to the estimate of total receipts given above gives a figure of between £3½ million and £5 million as the total of legacies to all organized charities in England and Wales. (It must be remembered

that this does not include charitable trusts setting up new endowed charities nor legacies to existing charities which are purely endowed.) It may be noted that there is actual evidence of a total of £2,300,000 in legacies. This total is the sum of the following amounts: voluntary hospitals average for 1931-34, £1,305,000, London charities (excluding hospitals) average for 1922-27, £935,400, Liverpool charities (excluding hospitals) average for 1923-33, £74,800.

The subtraction of legacies leaves the remaining 40 per cent as the probable proportion of total receipts contributed by all other forms of charitable gifts. This estimate applied to the estimate of total receipts given above gives a figure of between £14 million and £20 million as the total of charitable gifts other than legacies received by all organized charities in England and Wales. It may be noted that there is actual evidence of a total of nearly £10,300,000 in these charitable gifts. This figure is the sum of the following amounts: voluntary hospitals in 1934, nearly £5,000,000; London charities (excluding hospitals and nursing associations) in 1927, £4,800,000, district nursing associations in 1934, £380,000, Liverpool charities (excluding hospitals and nursing associations) in 1929, £130,000.

#### INTEREST

In 1927 the total amount received in interest by the charities in London included in the COS figures was £2,700,000—18 per cent of the total receipts of these charities. Among the nine main groups of charities the highest proportion of total receipts received in interest was 34 per cent. in the group covering homes for the aged and pensions, and the lowest was 10 per cent in the group covering charities for the blind.

The Liverpool figures for 1929 show a total of £165,800 received in interest—16 per cent of total receipts. Among the six groups of Liverpool charities the highest proportion of total receipts received in interest was 37 per cent in the 'poverty homes and pensions' group and the lowest was 4 per cent in the moral infirmity group.



The voluntary hospitals in England and Wales received in 1934 a total of £1,560,000 in interest—11 per cent of total receipts. The proportion was 13 per cent in London and 10 per cent in the provinces.

The figures for district nursing associations in England and Wales in 1934 do not classify interest separately—it is included in 'other sources of income' which amounted to £82,000—8 per cent of total receipts.

My conclusion is that probably about 13 per cent of the total receipts of all charities in England and Wales is received in interest. If we apply this estimate of 13 per cent to the estimate of total receipts given above we get a figure of something between £4½ million and £6½ million as the total amount received in interest by all charities in England and Wales. It should be remembered that purely endowed charities (whose incomes consist entirely of interest) are excluded from the estimates in this chapter, so that the figures given do not represent nearly all the income of all charities from interest.

It may be noted that there is actual evidence of a total of over £3,500,000 in interest. This total is the sum of the following amounts: London charities (excluding hospitals) in 1927, £1,860,000, voluntary hospitals in England and Wales, £1,560,000, Liverpool charities (excluding hospitals), £118,400.

The accumulation of property by charities is in nearly all cases the result (directly or indirectly) of charitable gifts in the past, so that in a sense the amount received in interest may be regarded as income from past charitable gifts.

#### RECEIPTS FOR SERVICES RENDERED

In 1927 the total amount received in payments for services rendered by the charities in London included in the C.O.S. figures was £4,700,000—32 per cent of total receipts. Among the nine main groups of charities the highest proportion of total receipts received in payments for services rendered was 48 per cent in the group covering charities for social and physical improvement, and the lowest was 5 per cent in the group covering charities for protection.

The Liverpool figures for 1929 show a total of £422,400 in receipts for services rendered—41 per cent of total receipts. Among the six groups of Liverpool charities the highest proportion of total receipts in payments for services rendered was 50 per cent in the moral infirmity group, and the lowest was 8 per cent in the temporary poverty group.

The voluntary hospitals in England and Wales had, in 1934, an income of £5,870,000 in receipts for services rendered—41 per cent of total receipts. The proportion was 32 per cent in London and 47 per cent in the provinces.

District nursing associations in England and Wales had, in 1934, an income of £597,000 in receipts for services rendered—56 per cent of total receipts.

My conclusion is that probably about 37 per cent of the total receipts of all charities in England and Wales is received in payments for services rendered. If we apply this estimate of 37 per cent to the estimate of total receipts given above we get a figure of something between £13 million and £18½ million as the total amount received in payments for services rendered by all charities in England and Wales.

It may be noted that there is actual evidence of a total of £10,160,000 in receipts for services rendered. This total is the sum of the following amounts: voluntary hospitals in England and Wales in 1934, £5,870,000; London charities (excluding hospitals and nursing associations) in 1927, £3,440,000; district nursing associations in England and Wales in 1934, £597,000; Liverpool charities (excluding hospitals and nursing associations) in 1929, £251,000.

There is, unfortunately, too little evidence and too much difference of classification for it to be possible to make an estimate of the total receipts in different types of payments for services rendered. The main types of receipts are payments by individual beneficiaries from the services of the charity, payments of contributors to compulsory or voluntary insurance schemes, and grants from public authorities. All these types are of considerable financial importance. The figures also include receipts of charities from trading services and industrial operations.

The following Table summarizes my estimates of the amount of the total receipts and of the main classes of receipts of all charities in England and Wales in 1934

ESTIMATE OF THE TOTAL RECEIPTS AND MAIN CLASSES OF RECEIPTS  
OF ALL CHARITIES IN ENGLAND AND WALES IN 1934

(Excluding purely endowed charities and purely religious and political organizations)

	Amount	Proportion of Total Receipts
Total Receipts .	£35 Mn to £50 Mn	100%
Legacies .	£ 3½ Mn to £ 5 Mn	10%
Other Charitable Gifts .	£14 Mn to £20 Mn	40%
<i>Total Charitable Gifts.</i>	<i>£17½ Mn to £25 Mn</i>	<i>50%</i>
<i>Interest.</i> . .	<i>£ 4½ Mn to £ 6½ Mn</i>	<i>13%</i>
<i>Receipts for Services Rendered</i> . .	<i>£13 Mn to £18½ Mn</i>	<i>37%</i>

THE PROPORTION OF THE NATIONAL INCOME  
EXPENDED IN CHARITABLE GIFTS

In his book 'National Income and Outlay,' Mr Colin Clark estimates that the net national income of the United Kingdom in 1934 was £4,238 million ('Net income' excludes maintenance and depreciation) As no separate estimate has been made for the national income of England and Wales, I shall assume for the purposes of this comparison that this was the same proportion of the national income for the United Kingdom as was the population in 1934 This assumption gives a figure of £3,674 million for the national income of England and Wales

On the basis of this estimate the figure of £17½ million to £25 million in charitable gifts in 1934 represented between about 0·5 per cent. and 0·7 per cent of the total national

income It should be remembered that this figure covers gifts to organized charity only and that it does not include gifts to purely religious or political organizations.

#### EXPENDITURE ON CHARITY IN A SAMPLE OF MIDDLE-CLASS BUDGETS

I know of only one published survey which gives any information on the proportion of individual incomes spent in charity This survey is contained in an article on 'The Cost of Living of a Sample of Middle-Class Families,' published by Mr D Caradog Jones in the 'Journal of the Royal Statistical Society,' Part 4, 1928 In this sample the budgets of 235 families were examined—50 in London, 62 in towns with over 50,000 population, and 123 in smaller towns The date of the investigation was 1926

The author estimated that on the average the families in the sample spent about 1½ per cent of their total expenditure on subscriptions and charities Both the amount and the proportion of total expenditure was larger in the small towns than in the large ones 'The money expended in subscriptions and charities, nowhere large, is greatest in the smaller places where the victim is most easily caught' There was not a very great range of variation in the proportions spent in subscriptions and charities by the majority of families in the sample in London three fifths of the families spent between 0·6 per cent and 2·2 per cent, in the large towns the same proportion of families spent between 0·7 per cent and 1·6 per cent, and in the small towns between 0·7 per cent and 2·2 per cent

#### TRENDS IN CHARITABLE FINANCE OVER RECENT YEARS

It is impossible to summarize in a short space all the information as to trends in charitable finance over recent years contained in this Section and in the discussions on finance in Section III But there is sufficient evidence for some general conclusions

(1) The total money receipts of charities have not fallen either in the post-War period as compared with the pre-War

period or over the course of the post-War period. The evidence of the figures for London, Liverpool, and the voluntary hospitals is that, though there have been decreases in some years, the general trend has been an increase throughout the period 1907 to 1934. The reliability of this conclusion is lessened by the variations in the number of charities included each year and by lack of information as to the trend in types of charities not included in the figures, but I think that the fact of the increase can be taken as true, though there is not sufficient evidence to warrant any estimates of the amount of the increase.

(2) The 'real income' of charities (i.e. the money receipts adjusted for changes in the cost of living index number) have possibly not increased in the post-War as compared with the pre-War period. This is the evidence of the London figures, which are the only figures giving a satisfactory basis of comparison, but these figures include no years later than 1927. The figures show that in all years between 1914 and 1927 the total 'real income' of the charities included was below that for 1914, and that in 1927 it had just risen again to the pre-War level. The figures of money receipts of charities are on the whole very steady from year to year and this means that they do not adjust easily to changes in the price level. Between 1914 and 1917 the real income of London charities fell by nearly 50 per cent, on the other hand it tended to rise throughout the period of falling prices from 1920 to 1927. There is further evidence of the effects of a falling price level in the figures for Liverpool and for the voluntary hospitals. Total receipts of Liverpool charities and of the voluntary hospitals increased considerably in the period 1925 to 1933 in terms of money, but they increased still more in terms of real income because of the fall of 20 per cent in the cost of living over that period.

It should be noted that, while a change in the price level obviously affects the 'real income' of charities, yet the quantitative effect is not accurately represented by the change in the cost of living index number. Some classes of charitable expenditure would be better related to the index number of wholesale prices, while some expenditure depends largely upon wage and salary rates.

(3) There is no doubt that the proportion of total receipts of charities received in charitable gifts has fallen in the post-War period as compared with the pre-War period and also over the course of the last decade. The London figures show a proportion of 59 per cent in 1908 compared with 50 per cent in 1927. If we exclude legacies from both charitable gifts and total receipts the proportions are 52 per cent in 1908 and 45 per cent in 1927. The figures for provincial voluntary hospitals show a proportion of 51 per cent in 1924 compared with 43 per cent in 1934. If we exclude legacies from both charitable gifts and total receipts the proportions are 46 per cent in 1924 and 34 per cent. in 1934.

On the other hand there is no doubt that the proportion of the total receipts of charities received in payments for services rendered has risen in the post-War period as compared with the pre-War period and also over the course of the last decade. The London figures show a proportion of 28 per cent. in 1908 and 32 per cent in 1927. The figures for provincial voluntary hospitals show a proportion of 37 per cent in 1924 and 47 per cent in 1934.

The general significance of these two trends is that charitable organizations now receive a larger proportion of the total cost of the services rendered from persons or groups benefiting by those services. A smaller proportion of the total cost remains to be met by charitable gifts. The function of these gifts is becoming more and more that of subsidizing services rather than of providing nearly the whole cost.

(4) Although there have been changes in the distribution of income between different types of charities the extent of these has been, in my opinion, surprisingly small, considering the many changes in social conditions and in the public social services which have occurred during the period. On the whole the charitable interests of individuals, as expressed in their charitable gifts, seem to remain very steady from year to year. (For evidence for these statements reference should be made to the London figures in Table 4 of Chapter VII, page 100, and to the Liverpool figures in Table 4 of Chapter VIII, page 121.)

A STATISTICAL COMPARISON OF THE RECEIPTS OF  
CHARITIES AND THE RECEIPTS OF THE PUBLIC  
SOCIAL SERVICES

THE POSITION IN 1934

The 'public social services' are usually taken to include those services for which figures are given in the annual Treasury Return entitled 'Public Social Services (Total Expenditure under certain Acts of Parliament)'. There is no hard and fast line between the services included in this Return and certain other services provided by public authorities. The recent 'Report on the British Social Services' published by P.E.P. (Political and Economic Planning) includes largely the same group of services as that included in the Treasury Return, but it excludes the war pensions services as making provision for special circumstances arising out of the Great War and most of the expenditure under the Housing Acts as not being concerned with personal services, and it includes certain additional services such as the services for the welfare of the blind and the placement work of the Ministry of Labour Employment Exchanges. The case for excluding expenditure on housing subsidies seems to me very doubtful. I agree with the contention of the Report that services for the welfare of the blind might well be included, but the expenditure on these services in 1934-35 was only £1,371,000, so that its inclusion would not greatly affect the total figures. War pensions may reasonably be considered as an item of expenditure which should be classed under defence expenditure rather than as a social service, but there is a strong argument in favour of including them in a comparison with charitable finance because a considerable amount of charity has been expended in the relief of disabilities and circumstances of distress arising as a result of the Great War. It seems to me therefore that there is no great objection to taking the figures conveniently assembled in the Treasury Return as roughly covering the public social services for the purposes of this comparison.

It will be obvious from what has already been said in this chapter that the available information on charitable finance does not allow of a detailed statistical comparison

with public social service finance all that can be attempted is a very general comparison

(1) It is clear that, whether the total receipts of organized charities in 1934 were £35 million or £50 million, or even a considerably smaller or larger amount than these estimates, the receipts were of small amount in comparison with the total receipts of the public social services. In the year 1934-35 the total receipts in England and Wales of the public social services included in the Treasury Return were £435 million (the total figures given in the Tables in this Return have been adjusted to include the Exchequer Contribution to the Treasury Pensions Account). It seems probable that the amount of receipts and expenditure of the public social services is about 10 times as great as the receipts and expenditure of charitable organizations—on my estimates it is between  $8\frac{1}{2}$  and  $12\frac{1}{2}$  times as great. (It should be noted that there is some duplication in the amounts included in public social service expenditure and in the expenditure of charities, as some public expenditure goes in grants to charitable organizations.)

(2) Just as the expenditure of charitable organizations is not financed entirely from charitable gifts, so the expenditure on the public social services is not financed entirely from taxes and rates. There are four other main sources of income in the public social services—interest and other income from property, payments from individuals benefiting from the services including some payments from voluntary insurance schemes, the contributions of workers to the three compulsory insurance schemes, and the payments of employers to these three schemes. (Capital expenditure from loans is not included in the figures of total expenditure.) These four sources of income are not separately classified in the Treasury Return together they amounted to £127 million out of the £435 million of total receipts—29 per cent of this total. The remaining £307 million was received from taxes and rates—71 per cent of total receipts.

Thus the public social services as a whole received a considerably smaller proportion of their total income from payments for services rendered than did charitable organizations, where the proportion was 37 per cent. In three



public social services—'unemployment assistance' (formerly 'transitional payments'), non-contributory old age pensions, and war pensions—the whole expenditure was financed from taxes or rates. Payments from beneficiaries were of large proportionate importance only in housing and in the three compulsory insurance schemes—unemployment insurance, health insurance, and contributory pensions. In the three insurance schemes payments from beneficiaries take the form of compulsory insurance contributions. While it is reasonable to regard the contributions of workers as a form of payment for services rendered, it is difficult to know how to regard the contributions of employers. It is arguable that these contributions should be regarded as a form of taxation and their amount added to the amount received from taxes and rates. But I shall not adopt this classification as it does not correspond to ordinary usage and as the whole subject of the incidence of employers' contributions is obscure and irrelevant to the subject of this enquiry.

(3) It is desirable to compare not only the figures of total expenditure of the public and voluntary social services but also the figures for that part of expenditure which is borne by the tax- and ratepayer and by the charitable contributor respectively. In 1934 £307 million was received by the public social services from taxes and rates and £17½ million to £25 million was received by charitable organizations from charitable gifts of all kinds. Thus the amount received from taxes and rates was 12 to 17½ times the amount received from charitable gifts. To state this conclusion in another form, the total burden of the social services falling upon the tax- and ratepayer and upon the charitable contributor was £324½ million to £332 million. Of this burden 92½ per cent to 94½ per cent was borne by the tax- and ratepayer and 5½ per cent to 7½ per cent was borne by the charitable contributor.

(4) For some purposes it is desirable to compare with the social service expenditure from taxes and rates what may be termed the 'net expenditure' of charitable organizations, that is, their total expenditure after the deduction of all payments for services rendered. (This, for example, is the classification with regard to charitable expenditure adopted in the sample survey of Cambridge which is quoted below.)

This 'net expenditure' includes, in addition to expenditure from charitable gifts, expenditure from the income of charitable organizations from interest. As compared with the £307 million expenditure from taxes and rates the 'net expenditure' of charitable organizations was £22 million to £31½ million. Thus expenditure from taxes and rates was 9½ to 14 times the amount of the 'net expenditure' of charities. The total expenditure of both kinds was £329 million to £338½ million, of which 90½ per cent to 93½ per cent was expenditure from taxes and rates and 6½ per cent to 9½ per cent was the 'net expenditure' of charities.

It would be interesting to know in which particular departments of the social services large amounts are spent from both taxes and rates and charitable gifts. The available information on charitable finance does not provide sufficient evidence for many detailed comparisons, but certain statements can be made with confidence.

The total expenditure in the year 1934-35 on unemployment benefits and unemployment assistance, old age pensions, and widows' and orphans' pensions was £166 million, out of which £106 million was expended from taxes and rates. In addition to this about £20 million was spent on domiciliary relief under the Poor Law—nearly all this amount was from taxes and rates. (This figure excludes expenditure on medical treatment, drugs and appliances, but it includes financial assistance to persons on account of sickness.) Thus the figures for the public social services included an amount of about £186 million, of which about £126 million was from taxes and rates, expended on general financial assistance to persons outside institutions. It is obvious that in comparison with these figures the amount spent by charitable organizations on similar purposes must be small.

The total expenditure under the Education Acts was £92 million, out of which £84 million was from taxes and rates. The main organized charitable expenditure on education is probably that of endowed charities, which are not included in the figures in this chapter. But even if endowed charities were included it seems unlikely that the total charitable expenditure on education can be of quantitative importance in comparison with the expenditure from taxes and rates.

The total expenditure under the Housing Acts was £40 million, out of which £16 million was from taxes and rates. In comparison with this figure the total expenditure of charitable organizations on housing must be very small.

It seems clear that the service provided by hospitals is by far the most important case of a social service on which large sums are spent from both taxes and rates and charitable gifts.

The Ministry of Health Local Government Financial Statistics, Parts 1 and 3, show that in the year 1934-35 the following amounts were expended on hospitals by local authorities in England and Wales

	Total Expenditure	Expenditure from Taxes and Rates
	£000s	£000s
<b>Expenditure of public health authorities on hospitals, sanatoria, dispensaries, etc .</b>		
For tuberculosis .	3,827	3,713
For venereal diseases	440	436
For other diseases (diphtheria, small-pox, etc )	3,852	3,659
General hospitals .	4,971	4,501
<b>Expenditure of Poor Law Authorities on the treatment of persons suffering from bodily or mental infirmity in Poor Law establishments</b>		
Institutional relief in Poor Law hospitals	2,381	2,148 (my estimate)
Institutional relief in infirmary wards or sick wards of Poor Law institutions (estimated proportion)	4,152	3,745 (my estimate)
<b>TOTAL EXPENDITURE</b>	<b>19,624</b>	<b>18,203</b>

These figures are of expenditure on Revenue Account and do not include expenditure from loans. The expenditure of

public health authorities includes some expenditure on dispensaries and does not include maternity or infant welfare hospitals. The expenditure of poor law authorities includes relief to cases of mental infirmity in poor law institutions but not in mental hospitals.

The available figures for the expenditure of voluntary hospitals in England and Wales include maternity hospitals but do not include tuberculosis sanatoria nor mental hospitals. These figures show in 1934 a total expenditure of £13,032,000, of which £11,005,000 was spent on maintenance and £2,027,000 was capital expenditure. The total receipts were £14,262,000, out of which £6,708,000—47 per cent—was received in charitable gifts. Thus we may estimate that 47 per cent of total expenditure, that is £6,125,000, was from charitable gifts.

On the basis of these two sets of figures the total expenditure of public authorities and charitable organizations on hospitals (excluding mental hospitals) amounted in 1934 to £32,655,000. Of this total, £19,624,000—60 per cent—was expended by public authorities and £13,032,000—40 per cent—was expended by charitable organizations. (There is some duplication here in the two sets of figures because of the inclusion in both sets of public grants given to voluntary hospitals. Some of the public expenditure, e.g. on venereal diseases and tuberculosis, is given partly in grants to voluntary bodies, so that the above figures are not entirely correct.)

The total expenditure on hospitals from both taxes and rates and charitable gifts amounted in 1934 to £24,328,000. Of this total, £18,203,000—75 per cent—was expended from taxes and rates, and £6,125,000—25 per cent—was expended from charitable gifts.

There are at least two other social services in which it seems probable that both public and charitable expenditure are of considerable financial importance.

The State assumed special responsibility for the welfare of the blind under the Blind Persons Act of 1920. In 1934–35 the total Revenue Account expenditure of local authorities under this Act was £1,371,000, out of which £1,141,000 was from taxes and rates. (This figure does not include expenditure on pensions to blind persons over 50 years of age, which are

paid directly by the central government and are included (with old age pensions) The London COS figures for charities for the blind in 1927 showed a total expenditure of £1,032,000 and total receipts of £1,023,000, out of which £454,000 was received from charitable gifts The figures for charities for the blind registered under the London County Council showed in 1932-33 a total expenditure of £729,000 and total receipts of £796,000, out of which £486,000 was received from charitable gifts Both these sets of figures include national charities for the blind in addition to London charities, but neither include all the charities in the country Thus it seems likely that both public and charitable expenditure on the welfare of the blind are of considerable importance

The London COS figures for 1927 showed a total expenditure of £1 738 000 on Homes for the young the total receipts of these charities were £1 982,000, out of which £1,453 000 was received from charitable gifts These figures include several large national institutions The only available figure of public expenditure on similar purposes is the figure for expenditure on children's Homes under the Poor Law this expenditure was £1 460 000 in 1934-35 Neither of these sets of figures is inclusive, but from their evidence it seems likely that there is considerable expenditure on the maintenance of children in institutions from both public and charitable funds

It should, of course, be remembered that a large amount of charity is expended on types of service for which the State takes little or no responsibility, or in which its responsibility is limited to its obligations under the Poor Law For example, this has been the case with regard to most of the general nursing work of district nursing associations

#### A SAMPLE SURVEY OF CAMBRIDGE

It is interesting to compare with my estimates for the whole country the results of a sample survey of Cambridge This survey was made by Dorothea C Morison (later Mrs Braithwaite), and was published in 1924 under the title 'State and Private Aid Cambridge 1922' The survey contains an exhaustive summary of social service expenditure

in Cambridge, and it is the only survey of its kind of which I know

The survey covers the two years 1920-21 and 1921-22. I shall quote the figures for the latter year only. The figures include all the expenditure on the social services in the Borough of Cambridge of both the central government and the local authorities, and also all the social service expenditure of organized charities, including endowed charities. 'Private charity, church collections, etc., are not included, neither is relief given by friendly societies or other similar bodies where the element of insurance is present. Such movements as the Boy Scouts, and Y M C A, etc., where the element of charity is small, are also excluded.' In all cases net expenditure only is shown, that is, expenditure after the deduction of payments of recipients for services rendered, and any sums earned in the course of their work by the agencies concerned. Thus the net expenditure of charities includes expenditure from interest in addition to expenditure from charitable gifts. The population of Cambridge in 1921 was 59,262.

The survey classifies all the expenditure on the social services under one of three headings—the relief of poverty, health services, and education. Below are given first the figures for all social services and then the figures under each heading

#### ALL SOCIAL SERVICES (INCLUDING WAR PENSIONS)

	Amount	Proportion of Total Expenditure.
	£	%
<i>Total expenditure</i> . . . . .	400,952	100
<i>Public expenditure</i> . . . . .	382,379	95.4
<i>Charitable expenditure</i> . . . . .	18,573	4.6

#### ALL SOCIAL SERVICES (EXCLUDING WAR PENSIONS)

	Amount	Proportion of Total Expenditure.
	£	%
<i>Total expenditure</i> . . . . .	283,682	100
<i>Public expenditure</i> . . . . .	265,109	93.5
<i>Charitable expenditure</i> . . . . .	18,573	6.5

The survey of Cambridge refers to the year 1921-22—thirteen years earlier than the year 1934, which is taken as the basis for the general estimates in this chapter, and in the

THE RELIEF OF POVERTY (INCLUDING WAR PENSIONS)		
	Amount.	Proportion of Total Expenditure
	£	%
<i>Total expenditure</i> . . .	248,198	100
<i>Public expenditure</i> . . .	240,078	96.7
<i>Charitable expenditure</i> . . .	8,120	3.3
THE RELIEF OF POVERTY (EXCLUDING WAR PENSIONS)		
	Amount	Proportion of Total Expenditure
	£	%
<i>Total expenditure</i> . . .	130,928	100
<i>Public expenditure</i> . . .	122,808	93.8
<i>Charitable expenditure</i> . . .	8,120	6.2
CLASSIFICATION OF EXPENDITURE ON THE RELIEF OF POVERTY		
	£	
<i>Total Public Expenditure (excluding War Pensions)</i> .	122,808	
Unemployment benefit . . .	25,200	
Old age pensions . . .	57,720	
Domiciliary poor relief . . .	13,837	
(Total expenditure on general financial assistance to persons outside institutions . . .)	96,757	
Poor relief to persons in mental institutions . . .	15,425	
Poor relief to persons in other institutions . . .	9,339	
Poor relief—administration . . .	1,287	
<i>Total Charitable Expenditure</i> . . .	8,120	
TOTAL EXPENDITURE (EXCLUDING WAR PENSIONS) .	130,928	
War pensions . . .	117,270	
TOTAL EXPENDITURE (INCLUDING WAR PENSIONS) .	248,198	

intervening period there have been many important changes in social service expenditure, particularly in some of the public social services. The Cambridge figures do not cover

exactly the same groups of charities and social services as the estimated figures for the whole country, and it is doubtful to what extent Cambridge is a typical example. But it seems to me that the Cambridge figures do supply confirmative evidence for three statements made earlier in this chapter

HEALTH SERVICES (INCLUDING ASSISTED HOUSING AND ALL PUBLIC HEALTH SERVICES—PREVENTIVE AND REMEDIAL)			
	Amount.	Proportion of Total Expenditure.	
	£	%	
<i>Total expenditure</i> . . . . .	57,227	100	
Public expenditure . . . . .	50,485	88 2	
Charitable expenditure . . . . .	6,742	11 8	

  

CLASSIFICATION OF EXPENDITURE ON HEALTH SERVICES	
<i>Total Public Expenditure</i> . . . . .	£ 50,485
Hospital and other treatment of infectious diseases, tuberculosis, and venereal diseases . . . . .	11,073
Mental hospital . . . . .	1,090
Other health services provided by the local authorities . . . . .	8,080
National Health Insurance benefits . . . . .	15,417
Assisted housing (excluding capital expenditure) . . . . .	14,825
<i>Total Charitable Expenditure</i> . . . . .	6,742
The voluntary hospital . . . . .	4,644
The district nursing association . . . . .	935
Other health services . . . . .	1,163
TOTAL EXPENDITURE . . . . .	57,227

(It should be noted that expenditure on health services under the Poor Law is included under 'the relief of poverty'.)

with regard to the country as a whole (1) that the 'net expenditure' of charities on the social services (i.e. their expenditure from charitable gifts and interest) is less than 10 per cent of the total 'net expenditure' on the social services of both public authorities and charities, (2) that charitable expenditure on general financial assistance to persons outside



institutions and charitable expenditure on education are small in amount in comparison with the expenditure of public authorities on these purposes, and (3) that the provision of hospital services is by far the most important case in which

EDUCATION (INCLUDING LIBRARIES AND THE GENERAL CARE AND TRAINING OF YOUNG PERSONS)		
	Amount	Proportion of Total Expenditure
	£	%
<i>Total expenditure</i> . . . . .	95,527	100
Public expenditure . . . . .	91,816	96.1
Charitable expenditure . . . . .	3,711	3.9

  

CLASSIFICATION OF EXPENDITURE ON EDUCATION	
	£
<i>Total Public Expenditure</i> . . . . .	91,816
Elementary education . . . . .	71,163
Secondary and other higher education . . . . .	17,127
General care and training of young persons . . . . .	246
Libraries . . . . .	3,280
<i>Total Charitable Expenditure</i> . . . . .	3,711
Secondary education . . . . .	1,678
Associations for the care of girls . . . . .	1,617
Other associations for the general care and training of young persons . . . . .	416
<b>TOTAL EXPENDITURE</b> . . . . .	<b>95,527</b>

(It should be noted that the University of Cambridge is not included in the survey)

large amounts are expended by both public authorities and charitable institutions.

#### TRENDS OVER RECENT YEARS

(This section should be compared with the section on 'Trends in Charitable Finance over Recent Years,' on pages 173-175 of this chapter)

(1) and (2) The following Table shows the total expenditure

on the public social services included in the Treasury Return for the years 1910-11, 1920-21, 1930-31, and 1934-35 (In the year 1910-11 the expenditure on maternity and child welfare work was not ascertained and is not included in the total figure, whereas it is included in the figures for the other years) The Table also shows the index number of total expenditure, taking expenditure in 1910-11 as 100, and also the index number of 'real expenditure,' that is expenditure when allowance has been made for changes in the cost of living

	Total Expendi- ture £000s	Index Number of Money Expenditure (1910-11 = 100)	Index Number of ' Real Expenditure ' (1910-11 = 100)	Cost of Living (1910-11 = 100).
1910-11	54,951	100	100	100
1920-21	271,350	493	191	258
1930-31	412,829	752	458	164
1934-35	426,849	776	532	146

There is no doubt that the expenditure on the public social services between 1910 and 1934 increased very much more than the expenditure of charitable organizations. (Compare these figures with those for London charities given in Tables 1 and 2 of Chapter VII, pages 92 and 93) There is also no doubt that this is true of the post-War period as well as of the period 1910-1920. The corollary of this fact is the fact that the proportion of total social service expenditure represented by the expenditure of charitable associations was much smaller in 1920 than in 1910, and in 1934 than in 1920.

When allowance has been made for changes in the cost of living, public social service expenditure is seen to have nearly doubled in the period 1910-1920, and to have increased  $2\frac{1}{2}$  times between 1920 and 1934. It seems possible that between 1910 and 1927 there was hardly any increase

in the 'real expenditure' of charities (see the London figures)

(3) From figures in the Treasury Return, and in the Report of the ('May') Committee on National Expenditure, it is possible to compare the proportion of the total receipts of the public social services received from taxes and rates and from other sources in 1911-12 and 1934-35 (These figures refer to Great Britain, not England and Wales) In 1911-12 out of total receipts of £62,800,000 receipts from taxes and rates amounted to £59,100,000—94 per cent of total receipts—and receipts from other sources amounted to £3,700,000—6 per cent of total receipts In 1934-35 out of total receipts of £495,500,000 receipts from taxes and rates amounted to £353,600,000—71 per cent of total receipts—and receipts from other sources amounted to £141,900,000—29 per cent of total receipts

These figures show that, although in 1934 the proportion of the total receipts of the public social services received from payments for services rendered, interest, etc. was probably considerably smaller than the corresponding proportion of the total receipts of charities, yet it had increased to a much greater extent since 1911. The main cause of this increase in the public social services was the establishment of the three compulsory insurance schemes, in which a large proportion of total income is received from the contributions of workers and employers

Although receipts from taxes and rates were a considerably smaller proportion of the total receipts of the public social services in 1934 than in 1911, yet there had been a large increase in their actual amount during that period. The amount of these receipts was £353,600,000 in 1934 compared with £59,100,000 in 1911, nearly six times as large in money income, and over four times as large if allowance is made for changes in the cost of living. There is no doubt that this increase was much larger than the increase in the receipts of charitable organizations from charitable gifts over the same period. The corollary of this fact is the fact that, as compared with the burden of social service expenditure borne by the tax- and ratepayer, the burden of expenditure borne by the charitable donor was much smaller in 1934 than in 1911.

(4) The following Table shows the proportion of the total expenditure on the public social services in England and Wales expended on different types of services in the years 1910-11, 1920-21, and 1934-35

	Proportion of Expenditure on all Social Services		
	1910-11	1920-21	1934-35
	%	%	%
Poor Relief . . . . .	27 4	11 7	10 0
Old Age Pensions . . . . .	11 5	6 8	8 9
Contributory Pensions . . . . .	Nil	Nil	9 0
War Pensions . . . . .	Nil	33 5	8 7
Unemployment Insurance and Assistance . . . . .	Nil	3 6	19 9
National Health Insurance . . . . .	Nil	9 7	7 7
Hospitals and Treatment of Disease under Public Health Acts . . . . .	3 4	2 7	2 9
Housing . . . . .	1 4	1 6	9 4
Education . . . . .	52 8	28 1	21 5
All other Services . . . . .	3 6	2 3	2 1

If this Table is compared with the figures for London in Table 4 of Chapter VII, page 100, and with the figures for Liverpool in Table 4 of Chapter VIII, page 121, it will be seen that over the period 1910-1934 the changes in the distribution of public social service expenditure were much greater than the changes in the distribution of the expenditure of charitable organizations. During the period the three compulsory insurance schemes were established, expenditure on war pensions became necessary, and there was a large increase in

the expenditure on subsidized housing. Thus the two main items of expenditure in 1910—education and poor relief—while both increasing by about three times in actual amount became much smaller proportions of the total expenditure on all services.

### AN ECONOMIC COMPARISON OF CHARITY AND PUBLIC FINANCE

The previous pages have tried to assess the comparative quantitative importance of charity and public finance in the provision of social services. What follows will compare the two methods of provision with regard to some of their economic aspects, pointing out the similarities and contrasts between them. This discussion is confined to the differences arising from the method of raising the income to be spent; it is not concerned with the differences of the method of spending money raised to finance a particular social service. (Such a discussion would involve the whole subject of the methods of administration of the public and voluntary social services, which is outside the scope of this Section.)

The whole of social service expenditure, whether public or voluntary, is essentially the spending of income on the needs of others, as contrasted with the expenditure of an individual of his own income to satisfy his own needs. This fact makes it very difficult to apply the marginal utility analysis to social service expenditure without considerable modifications. This analysis assumes that the consumer can make a fairly accurate comparison between the utility to him of the marginal unit bought of any commodity or service and the marginal utility to him of the money which he expends in buying such a commodity or service. The same individual makes the sacrifice and reaps the benefit and he can make a direct comparison between the two. (Of course when an individual is spending on behalf of his dependent family this ceases to be true, but the fact that their needs are very well known to him, and that, in greater or smaller measure, he tends to regard them as he would his own makes the comparison between benefits and sacrifices much less difficult than in the case of social service expenditure.)

In general an individual assesses the needs of others not in his immediate family as less urgent than his own in their claim upon his income. He does not regard them as of no urgency or there would be no charity, he does not regard them as of equal urgency or there would be no need for compulsion. The essential difference between charity and compulsory contributions to the social services is that, in the first case, the assessment of urgency is left to the individual donor, and that, in the second case, the assessment is made for him by the representative organs of the whole State.

There are two aspects of this comparison which need discussion—the total amount expended on the social services, and the distribution of that amount between different services, but the two aspects are intimately connected. Neither public authorities nor charitable organizations collect money to finance social services in general, they collect to meet expenditure on particular services. But public authorities, when once this expenditure has been authorized, collect their income from all citizens, whether or not those citizens are interested in any of the particular services in question. Charitable organizations, on the other hand, are dependent for their contributions not only on the general willingness of donors to spend on social services but on their willingness to spend on the particular service in question. Charitable donations are given by the individual for specific purposes, rates and taxes are not. There is likely, therefore, to be a much closer relationship between an individual's contribution and his assessment of the *particular* needs of others in the case of charity than in the case of compulsory contributions. Charity gives scope for variation between individuals in their opinions as to the relative importance of different types of needs of other people in the same way as a condition of individual expenditure of income in general gives scope for variations between individuals in their opinion of the relative importance of their own needs of different types.

An individual donor's assessment of the comparative marginal utility of different types of charitable expenditure will be affected by several kinds of circumstances. (Of course many charitable donations are given in a very haphazard

manner, for example, contributions to flag days, but I am considering the cases where the contribution is made more deliberately) The individual must first have the charity in question brought to his notice in some way Here the lack of co-ordination in charitable effort means that while some types of charity are very well known other types are known only to few An individual's actual assessment does not therefore necessarily represent what his assessment would be if he knew all the relevant facts With regard to the types of charity known to him, he will be influenced partly by his own special interests and by what types of need he has encountered in his personal experience For example, a keen Catholic will be interested in charities for Catholics and in charities engaged in Catholic propaganda, an individual who has personal experience of the problems of deafness in his own case, or among his family or friends, will be interested in charities for the deaf Many donors are much influenced by social convention and like to subscribe to charities widely supported On the other hand, a donor sometimes takes the view that, while such charities are useful, the very fact of the widespread support given to them makes the *marginal* utility of his subscription greater if given to charities with few subscribers The comparative assessment of the needs of charities in different localities is discussed in another paragraph

In contrast to this position public authorities have a much wider knowledge than an individual donor of all the different types of need existing in the community They have also knowledge of the amounts spent by themselves in the provision of all types of social service, which knowledge is lacking in the case of charitable expenditure They therefore have a much more accurate and extensive basis of known facts on which to make their assessments of the comparative needs of different branches of social service, though this knowledge is not always used, owing to the defective co-ordination between separate departments of both the central government and local authorities Local authorities have not complete control over the distribution of their expenditure, as they must provide certain services, cannot legally provide others, and are subjected to financial control of various kinds

by the central government with regard to the services provided, but there still remains to them scope for variation of expenditure. The central government can, in theory, distribute its expenditure as it wills. In both cases the distribution of expenditure reflects the average wishes of the majority of the electors, or rather of those of them who take the trouble to express an opinion. But the expression of this opinion is general not specific—the majority of the electors approve of the general policy of their representatives (which, of course, covers other matters besides administration of social services), but they do not actively approve of every individual variation of expenditure, though if they actively disapprove they will probably voice their opinions. Thus, as compared with charitable expenditure, expenditure on the social services by public authorities works under conditions one stage further removed from the conditions of individual expenditure on individual needs. In both cases the needs satisfied are not those of the spenders of the money, but in the case of public expenditure there is the additional circumstance that the wishes of the spenders are known only roughly and on the average.

There are two further differences between charitable and public expenditure which are very important. One difference is that public expenditure reflects the wishes of the electors irrespective of their financial position, whereas charitable expenditure reflects the wishes of the donors weighted by what they can afford to contribute. There are qualifications to this statement from both sides—finance plays much part in politics and, on the other hand, even the small subscriber to a charitable organization can often voice his opinion with regard to the policy of the organization. But in general the contrast is very important, and its essence lies in the second further difference between public and charitable expenditure—the fact that the first is compulsory and the second voluntary. However much the poor subscribers to any particular branch of charity may wish that charity to be extended they cannot enforce their wishes—they can subscribe as much as they can afford themselves, and they can use their efforts to persuade richer people to subscribe, but further than that they cannot go. With regard to a public social service, on the other hand,



the majority of the electors can determine the extent of expenditure and raise the necessary money, if they wish, entirely or preponderantly from those richer than themselves, because they can use compulsion to levy the necessary taxes, rates, and insurance contributions

These two related differences between charitable and public expenditure probably affect the question of the distribution of social service expenditure between different types of service. But they affect much more the question of the total amount spent on the social services. If all social service expenditure were voluntary it is impossible to say whether it would be distributed between different services in much the same proportions as is present social service expenditure, public and voluntary together. What is certain is that the total amount expended on the social services would be much smaller. It is only the exceptional person who would be willing to contribute voluntarily, in addition to what he gives voluntarily at present, the amount which he pays compulsorily. There are several reasons for this. One reason is that many people are not charitably inclined, at any rate not sufficiently to meet the needs of the social services. Another reason is that, even among those charitably inclined, there is no direct correlation between willingness to contribute and ability to contribute. A third reason is that many people are perfectly willing to 'pay their share,' provided that others do likewise. compulsory taxation can ensure that every one pays his share (however that may be interpreted), while the burden of charitable expenditure falls on the willing to the exclusion of the unwilling or uninterested.

On the question as to whether the compulsory donor makes a greater marginal sacrifice in his donations than the voluntary donor there are two opposing considerations. On the one hand, taxation can be graduated in accordance with ability to pay, whereas this is impossible in the collection of charitable contributions. Thus much money is collected in taxation which would involve greater marginal sacrifice if it were collected voluntarily, and this would be even truer if taxation pressed comparatively more severely on the rich than it does at present. On the other hand, a voluntary contribution by an individual is probably felt to be a lesser sacrifice than a

compulsory contribution of the same amount, especially as it can be allocated more accurately in accordance with his wishes. There are less likely to be harmful indirect economic effects from the collection of charitable gifts than from the collection of compulsory contributions: an individual's desire to work or save will not be diminished because he gives largely to charity, whereas it may be diminished by high taxation. (Both forms of contribution may diminish his ability to save.)

An economic advantage of public over charitable finance is that the expense of collecting contributions is a much smaller proportion of the total amount collected, owing to the fact that the tax- and ratepayer is compelled to contribute instead of having to be persuaded to do so. This statement is often not true of money expenses in cases where the collection of charitable contributions is done by voluntary workers, but it is true of the 'real expenses' of labour and time involved.

An economic problem common to all forms of social services is the problem of the comparative importance of local and non-local sources of income. Some public social services, for example, poor relief in the past, and some voluntary social services, for example, the voluntary hospitals, have collected their income almost entirely from local sources. On the other hand, some public social services, for example, old age pensions, and some voluntary social services, for example, some forms of institutional provision for children, have received large amounts of income from contributors over the country as a whole. In general the same kinds of circumstance determine whether a locality can well afford to support both the public and voluntary social services needed by persons in its area. It is difficult to finance both types of social service in areas where the population is scattered, in areas where the majority of the inhabitants are poor, and in areas where the main industries are depressed. The State has partially met this difficulty in the case of public social services by the provision of the service directly by the central government, or by grants in aid of particular services, or by general grants to localities based on the needs of those localities. In the case of voluntary social services the difficulty has been met in some cases by the organization of the

service on a nation-wide basis, in some cases by grants to the local organizations from county or national federating bodies, in some cases by direct appeals on behalf of charity in particular localities to subscribers in other parts of the country. But there remains a great difference between the standard of provision of the same social service in different localities. This difference is found in both public and voluntary social services, but the particular localities which have good and bad provision are not always the same with regard to different types of service, nor with regard to voluntary as compared with public social services. This is because the adequacy of provision of any locally financed service depends not only on the financial resources of local citizens but on their willingness to contribute. In the case of some voluntary social services the effect of the comparative smallness of financial resources in rural areas and small towns is sometimes offset by the greater accessibility of potential donors to the collectors of subscriptions and by their more intimate knowledge of the needs of their neighbours.

An important difference in the geographical distribution of public and voluntary social service expenditure is that the British State rarely contributes to social services outside the country, or the British Empire, whereas a considerable amount of charitable donations is given by British citizens to finance services in other countries.

## **SECTION III**

### **DISTRICT NURSING ASSOCIATIONS: AN EXAMPLE OF A VOLUNTARILY ORGANIZED SOCIAL SERVICE**



## CHAPTER XII

### SUMMARY OF THE HISTORY AND GENERAL POSITION OF DISTRICT NURSING

#### DISTRICT NURSING ASSOCIATIONS AS TYPICAL CHARITIES

THIS Section is a description of the organization and problems of district nursing associations in England and Wales. The work of the associations is treated not from a professional standpoint but as illustrating the kind of work done by voluntary charities, the kind of organization developed to do that work, and the problems of various kinds involved. The considerable amount of detail given in the description of some associations is given not because of any intrinsic importance of that detail, but because a detailed study of certain parts of the field covered by philanthropy throws light on many aspects of activity which are not adequately described by the kind of statistical survey given in Section II.

Granted the value of a detailed study of part of the field, why have district nursing associations been chosen? I was influenced to some extent in my choice by personal interest in the Association of my native town. But I also considered that district nursing associations are in many ways very typical British charities, and that, unlike the voluntary hospitals, the professional problems involved are not very complicated. The associations are typical charities in that they now cover a very large proportion of the total area of the country, and are found in all types of districts from the Metropolis to rural Wales. Thus they give some scope, in a way which many charities do not, for comparing the organization and problems of urban and rural areas. They appeal to the interest of all classes and sections of the community, and there is no difference of opinion as to the general value of the work done by them. They have co-operated for certain

purposes with public authorities. They have been affected to a considerable extent by the development of voluntary insurance schemes.

There are, however, two problems which are important in many forms of charities and which are of no importance, or of very minor importance, in the work of district nursing associations. The first of these is the set of problems involved when charitable relief is given in money as opposed to a particular service. The second is the problem of the place of the unpaid voluntary worker as opposed to the paid professional worker.

### THE HISTORY OF DISTRICT NURSING

This chapter will give a brief survey of the history and present position of district nursing in England and Wales as a preliminary to the detailed study of three areas of different types given in the three succeeding chapters.

The first district nurse, i.e. the first nurse employed for a salary to do visiting nursing in people's homes, started work in Liverpool in 1859. The person responsible, in the first place, for employing her was William Rathbone, who, 'having experienced the advantage of skilled nursing in the case of illness in his own family, conceived the idea of carrying these benefits to the homes of the poor.' He had the co-operation of the Liverpool Royal Infirmary in the training of district nurses. The service was soon taken over by a district nursing society employing nurses all over the city. Manchester formed a society in 1864, Leicester in 1867, and Birmingham in 1870. Meanwhile, in 1868, two organizations had started district nursing in London—the East London Nursing Society, and the Ranyard Biblewomen and Nurses' Mission. They were followed in 1875 by the Metropolitan and National Nursing Association, initiated by the Order of St. John of Jerusalem.

These nursing associations were all in urban areas. The first rural district nursing association was formed in 1888, followed in 1891 by the first county association—in Hampshire. Rather earlier—in 1883—the Cottage Benefit Nursing Association had been formed to supply resident nurses in country districts.

In 1889 the Queen Victoria's Jubilee Institute for Nurses (now the Queen's Institute of District Nursing) was formed with part of the Women's Jubilee Offering to Queen Victoria, a sum of £70,000. The effect of the founding of the Institute was, in Dr Arthur Shadwell's words, 'to co-ordinate the work, give it a permanent centre, standardize and improve the training of nurses, increase their number, stimulate the formation of local associations and turn a scattered service into a national system capable of further development on sound lines' (Article in 'The Times,' 28th September 1926). (The Queen's Institute of District Nursing will be referred to as 'The Queen's Institute' throughout this Section.)

The increase in the number of nursing associations is shown by the following figures (which, however, apply only to those county associations affiliated to the Queen's Institute, and to those district nursing associations employing 'Queen's Nurses').

	1893	1903	1923	1933	1934.
County Associations		10	42	43	45
District Associations	131	388	688	963	1,006

The work of district nursing associations was much affected by the Midwives Acts, 1902 and 1918, the Notification of Births Acts, 1907 and 1915, and the Maternity and Child Welfare Act, 1918, and the Education (Administrative Provisions) Act, 1907. It will probably be much affected in future by the Midwives Act, 1936. The effect of these Acts is described in Chapter XVI.

#### THE PRESENT EXTENT OF THE SERVICE

The Queen's Institute published in Autumn 1935 a 'Survey of District Nursing in England and Wales,' giving figures as to the extent and adequacy of the service throughout the country. The information was collected at the end of 1934.

This Survey shows that, at that date, 95 per cent of the population of England and Wales was covered by district nursing associations. These associations employed a total of 7,285 nurses.



A separate set of figures for those associations connected with the Institute shows that at 31st December 1934, there were forty-five affiliated county associations, and 1006 district associations employing Queen's Nurses. These district associations, and local associations affiliated to the county associations employed a total of 6,157 nurses. Of these nurses, 2,513 were 'Queen's Nurses,' 2,823 were 'Village Nurse-Midwives,' and 821 were other nurses, including candidates in training. 'Queen's Nurses' are nurses who have trained in approved hospitals for not less than three years and are State Registered Nurses. They are then given an approved training in district nursing for not less than six months (four months only if they already hold a Health Visitor's Certificate), including maternity nursing and a course of theoretical instruction, followed by a simple theoretical and practical examination in the work of a district nurse. Those acting as midwives must also be certified under the Midwives Acts. 'Village Nurse-Midwives' are nurses who have not had such long training. They are certified midwives with some training in district nursing. The usual course of training at present is one year's training in midwifery (some in hospital, and some in district work), followed by three to six months' training in general district nursing. In addition, if they are going to include Public Health work in their duties, they will have one or two months' training in it. They are usually employed only in rural areas and small towns and come under the supervision of the Superintendent of the County Nursing Association.

#### DEPARTMENTS OF WORK OF DISTRICT NURSES

There are three main departments of work of district nurses. In all areas general nursing is done. In most rural areas and some towns, though not in most large cities, midwifery and maternity nursing is also done, either by the same nurses or by special nurses employed by the same associations. In some rural areas public health work, e.g. maternity and child welfare work and school nursing, is done by district nurses for the public authority. These departments of work are described in Chapter XVI and also the relations with public authorities with regard to each type of work.

## THE AREAS SELECTED AS EXAMPLES

In the following three chapters three areas are selected for detailed study. Birmingham is studied as an example of a large city, Banbury as an example of a small town, and a district of villages in Oxfordshire as an example of a rural area. These three areas between them provide examples of most of the types of organization and of problems met with in district nursing. The organization of district nursing in London has already been made the subject of a special study—Dr Margaret Hogarth's 'Survey of District Nursing in the Administrative County of London,' published by the London County Council in 1931.

In the whole of the following description of the organization of district nursing the position described as the present position is that existing in the year 1934, unless some other year is given. In certain cases, where important changes have taken place since that date, later information has been added.

## CHAPTER XIII

### DISTRICT NURSING IN A LARGE CITY— BIRMINGHAM

#### THE HISTORY OF DISTRICT NURSING IN BIRMINGHAM UP TO 1928

**THE** history of district nursing in Birmingham is a good example of the steady development of a voluntary social service in a constantly expanding city. It started more than sixty years ago in the financing by a group of benevolent ladies of one nurse to work among the poor in a central crowded area. It has developed into a vast service employing 80 to 90 nurses, covering the whole of the City's million inhabitants, and controlled in the main by one association formed by the amalgamation with the central society of the smaller societies existing in the outlying areas. Originally supported almost entirely by the well-to-do, the central association now raises over 70 per cent of its income in payments from or on behalf of those nursed, and a considerable further amount in small charitable subscriptions from working-class people.

The following account is a summary of the history of the central society. The history of the other societies before the amalgamation will sometimes be mentioned but the account does not profess to cover their history.

The Birmingham District Nursing Society was founded in 1870. (It was originally called the Ladywood District Nursing Society, as Ladywood was the district where the first nurse worked.) The small committee which formed it included members of some of the same families still prominent in the present Association.

At that time trained nurses were very scarce not only for the poor but even for those who could afford to pay for their services, and a year previously the Birmingham and Midland

Counties Training Institution for Nurses had been founded. Its objects were to provide trained nurses (1) for the hospitals, (2) for private families, (3) 'as early as possible gratuitously for the sick poor'. It is interesting to note this attitude as it has characterized district nursing throughout all its history unlike many other forms of charity which have only hoped to give the poor the second best, district nursing associations, at any rate in the large towns, always seem to have aimed at giving the poor the best nursing skill available.

From this time until its winding up in 1909 the Training Institution gave substantial help to the District Nursing Society, first by sharing responsibility for the cost of some of the nurses, later by giving an annual grant, and finally by leaving its surplus funds to the Society when it was wound up.

In the first year of the Ladywood District Nursing Society the nurse attended 96 cases. A report two years later speaks of the nurse's 'good influence in the district where unfortunately she meets with much ignorance and prejudice'. However, despite this prejudice, the work had increased so much by 1876 that the Society were urging the necessity for another nurse and for further subscriptions to finance her. 'They trust that ladies and gentlemen living on the south side of Edgbaston will come forward with subscriptions and enable your Committee to do for St. Thomas' Ward what the inhabitants of the part of Edgbaston nearest to Ladywood have put it in their power to effect for that district'. In the next year the second nurse started work and a Nurses' Home was started. Ten years later the number of nurses had increased to six.

In 1894, forty years ago, the Society had ten nurses at work and had just started the first branch work at Saltley. Its claim at this date that it 'is supported entirely by voluntary contributions and has for its sole object the Nursing (free of charge) of the Sick Poor' is borne out by its statement of accounts. Patients' payments are represented by 5s. from a 'grateful patient' and by that alone. Grants from public authorities are represented by ten guineas from the Board of Guardians (first given two years before). Except for a small amount of interest, all the rest of the £800 of the Society's income came from voluntary charity. About two

fifths of this income from charity was given direct to the Society. The other three fifths was given indirectly through the above-mentioned Training Institution for Nurses, the Hospital Saturday Fund, the Hospital Sunday Fund, and the Birmingham General Dispensary

There was also a considerable amount of charity involved which never enters into the annual statement of accounts. In the reports for this period there are constant appeals for nourishment for the cases nursed, also for Dispensary and Sanatorium tickets, warm clothes and materials for bandages and dressings. At the present time there is still need for these forms of supplementary charity in some cases, but the great diminution in the amount of extreme poverty has made them a much less important part of the whole work.

Besides giving financial help some of the supporters of the Society showed their interest in the work by visiting with the nurses weekly or fortnightly. 'Your Committee again wish to thank those ladies who kindly undertake to visit with the nurses, encouraging them by the interest shown in their work, and cheering many patients through the long weeks of suffering and weakness illness so frequently entails.' This practice went on from 1888 to 1901, when it was discontinued and not afterwards revived—for reasons which are discussed below.

In 1895 the Society affiliated with the Queen Victoria Jubilee Institution for Nurses (now the Queen's Institute of District Nursing) which had been founded six years previously. This was an important step. The Institution provided an annual inspection and thus gave the Committee of the Society the benefit of expert outside criticism and the public a guarantee of the standard of the work done. It also provided qualified nurses as candidates for appointment by the Society and later arranged for the Society to train nurses in district work on its behalf.

In the next year the Society showed further evidence of its desire to keep up its standards. It sent two of its members to see the district nursing work at Liverpool and Manchester, where work was being done on a much larger scale than in Birmingham. As a result of this visit it was decided to make an effort to increase greatly the number of nurses employed and the area covered. It was hoped to employ about thirty-

five nurses instead of the fifteen already working. This would give a proportion of one nurse to every 10,000 of population, a proportion already achieved in Liverpool and Manchester. It was proposed to house these nurses in four district Homes in the North, South, East, and West of the City, each in charge of a Superintendent or Head Nurse.

This ambitious scheme was not accomplished for many years—in fact, it was never accomplished according to that plan. A second Home, now known as the South Home, was opened in Moseley Road in 1897. This was made possible largely by a grant of £2,500 from the Birmingham Diamond Jubilee Fund. (At the same time a Jubilee Fund was collected in Aston Manor. This Fund was used to set up a Nurses' Home under a separate society—the Aston Manor Nursing Institution, which still continues to work independently.) In 1909 the Birmingham Society established a third Home in Saltley, now known as the East Home. Between that year and the time of the amalgamation no further Homes were established, but the number of nurses increased until there were 32 in 1928.

In 1900 the Society started on a piece of work which paved the way for what is now a very important public social service. The headmaster of Staniforth Street Board School applied for a nurse to visit the school to dress the numerous cuts, sores, and wounds from which the boys were suffering. The Society provided that one of its nurses should visit the school in the course of her duties, and about thirty children a day were attended to. In the following year two more schools were added and special donations were given for the purpose. The cost of the work was about £12 to £15 per school, and there were no public grants available for the purpose. In 1902 four schools were being visited, and 18,400 separate treatments were given during the year. In the next year the number of schools had increased to six, occupying the whole time of one nurse. The greater part of the cost was contributed by those interested in the schools. This was the peak of the Society's work in this field. After this the number of schools was reduced, partly owing to lack of adequate financial support, and in 1908 the nurse was withdrawn from the last school. The committee justified this step by saying that there was

more urgent work for the nurse to do, and also by referring to the Education (Administrative Provisions) Act, 1907. This Act set up a system of medical inspection and treatment under the Local Education Authorities. Since that date the Society has done no work in schools, except in one Catholic Elementary School from 1911 to 1920.

In 1902 a very important step was taken with regard to the finances of the Society. Up to that time nearly all the income of the Society had come either indirectly in grants from other charities or in annual subscriptions and donations, mostly of fairly large amounts. In 1899 there was for the first time a considerable deficit and a special appeal was organized with little response. The deficit continued for the next two years, and it was decided that an appeal should be made to a wider public by the organization of annual house to house collections. This organization was carried out by a 'Ladies' Auxiliary Fund'. In the first year the fund collected about £500, and made a grant to pay the Society's deficit of £297. From 1902 to 1914 it contributed between £200 and £300 annually, from 1915 to 1920, £300 to £400, from 1921 to 1924, amounts varying between £300 and £530, and from 1925 to 1928, about £400. After 1928, when the Society was merged in the new Association, the fund as such ceased to exist, but the house to house collections were greatly extended, being organized by the Councils for the various areas.

The 1904 Annual Report is the first to mention the use of bicycles by the nurses, but the committee note that they do not consider them safe in crowded or narrow thoroughfares.

In 1907 the Newhall Street Home was recognized by the Queen's Institute as a training centre for district work, and there were two probationers training there.

In 1908 the Central Home was transferred from Newhall Street to Summer Hill Road. Special buildings were erected at a cost of about £4,000. The statement that the new buildings are 'in a very open situation at the top of the hill' unfortunately reads rather ironically twenty-seven years later!

The passing of the National Insurance Act of 1911, which established a system of compulsory health insurance, made little immediate difference to the work of the Society, but its

later effects were important. Nursing was not at first included as a possible benefit under the scheme, and in 1913 there was a conference in London between delegates of District Nursing Associations and of Approved Societies, which decided to approach the Government with a view to persuading them to include it in the next amending Act. In the amending Act of 1920 domiciliary nursing was included as an 'additional benefit,' and in 1921 the Queen's Institute concluded an agreement with two large Approved Societies. This was followed in later years by other similar agreements made by the Institute on behalf of its affiliated societies. In 1922 the Birmingham Society received £43 from Approved Societies as a payment for nursing services to their members, in 1928 this had risen to £257, and in 1934 the amalgamated Association received £543 from this source.

A new branch of work was started in 1913—the provision of a works nurse for the B S A factory. At first only the women and girls came to her, but soon the men came also. In 1914 a second nurse was supplied to the firm. In 1915 six nurses were being supplied by the Society for munition workers, three at the B S A works and three at the Electric and Ordnance Company's works, and later the number was increased to ten. The Committee regarded this as important work. However, it ceased in the following year, as the Ministry of Munitions arranged to supply their own nurses. At the present time there is one case in the City where a nurse employed by the Association attends at a factory.

The Great War, with its large demand for the services of skilled nurses, made the position of district nursing societies throughout the country very difficult. The Birmingham Society felt obliged to abandon its principle of employing only fully trained nurses and accepted the voluntary help of members of the nursing division of the St. John Ambulance Brigade. In 1915 these ladies paid about 8,400 visits. They continued their help all through the War period and after it, at least up to 1923. The Society much appreciated their services, but has not had any need to use them since that date, except very occasionally in emergencies.

The War affected adversely the Society's finances. It popularized flag days, however, and in 1918 the Society had



its first Flag Day and Special Appeal, raising about £2,700, out of which over £2,000 came from the Special Appeal. In 1920 the financial situation was so bad that the Society was arranging to close the South Home. However, the situation was saved by the work of the Augmentation Fund Committee, which was set up with a paid organizing secretary, who a year later became the paid secretary of the Society. A flag day was held again in 1922, and since then has been held annually (In 1934 it raised £657). The Report for 1923 gives the reader the impression that in that year the Society had managed to turn the corner financially.

One of the reasons for this improvement in the financial position was the growth of patients' payments. In 1904 these were insignificant (£11), ten years later they had risen to £95. In 1920 the Society, for the first time, omitted the words 'free of charge' from its statement of objects and decided to follow the example of similar societies in other large towns by charging a small fee. The suggested charge was 1s a visit and 6d for two in a day. No charge was to be made to those receiving Poor Law relief or Old Age Pensions. Voluntary gifts from patients would still be gratefully received, as the suggested charges would not cover the costs. However, this scheme of definite fees was soon found to be unworkable. In 1921 it was noted that it had been found impossible to enforce the suggested charges 'in this time of poverty and dire distress,' but patients were asked to pay according to their means—the principle which has been continued.

In 1915 the Society for the first time was called upon to do some work directly for the City Council. The Medical Officer of Health asked that the Society should provide the services of one nurse to attend cases of measles which came under his authority, and in that year 276 cases were attended. Three years later there was further co-operation with the City Public Health Department, this time to cope with the serious influenza epidemic of that year. Since 1921 the Society and later the amalgamated Association have nursed every year hundreds of cases of certain specified diseases for the Public Health Department, for which payment has been made at a fixed rate per case.

The Society has in recent years made one incursion, and

one only, into the field of midwifery. In 1921 the Central Home engaged a midwife, making charges for her services according to the rate usually paid in the district. The step was taken because at that time independent midwives found it very difficult to make a living in that district and consequently there was a dearth of them. It was considered by the Committee to be successful and in 1923 a second midwife was appointed. The service was carried on in the Central Area until 1929, when it was discontinued. By this time there were more independent midwives in the neighbourhood, and there had been an increase in institutional accommodation for maternity cases, so that the need had ceased. Midwifery was also undertaken for a short time in the early days of the Erdington District Nursing Society.

Until 1928 the Birmingham Society kept within the boundaries of the City area as it had existed before 1911. But, alongside the central Birmingham Society, district nursing societies had grown up in other parts of what is now the City area. The other societies were the following, founded at about the dates given:

Handsworth	1879
Harborne	1891
Selly Oak and Bournbrook	1892
Erdington	1893
Aston Manor (in circumstances described above)	1899
Acock's Green and District	1899
Hay Mills and South Yardley (formerly one association, separated in 1915)	
Sparkhill and Greet	1900
King's Heath	1901
Selly Hill, Ten Acres, and Dogpool (now Selly Park and Dad's Lane Estate)	1906
King's Norton, Stirchley, and Cotteridge	1909
Billesley	1928

All these other societies were on a much smaller scale than the Birmingham Society though, as will be noted, many of them had long records of service. In 1927, as compared with the 31 nurses employed by the Birmingham Society, Aston

Manor employed four nurses, Erdington employed three, and the other societies then existing employed one or two each. All together they employed 20 nurses at that date

The organizers of district nursing in Birmingham have been faced with a constantly increasing demand for their service, not only because of the rise of social standards, but because of the great increase of population and the many extensions of the boundaries of the City. The population of the Borough of Birmingham in 1871, a year after the founding of the Society, was 342,500. In 1931 it was 1,002,600—almost three times as great. In 1891 the area of the City was increased by one half by the addition of Saltley, Little Bromwich, Harborne, and Balsall Heath, and in 1909 Quinton was added. In the Greater Birmingham scheme of 1911, Aston Manor, Erdington, Handsworth, King's Norton, Northfield, and Yardley, with a total population of 315,000, were included in the City. In and since 1928 portions of Perry Barr, Castle Bromwich, Sheldon, Minworth, and Solihull have been added.

The problems caused by the increase of population became complicated by the spreading of that population over much wider areas in the new housing estates. In their Report for 1926 the Committee of the Birmingham Society state that they 'have long been aware that there are many parts of Greater Birmingham where no District Nurse is available, and from time to time they have received urgent calls to send a nurse to some more or less isolated spot. All the Nursing Societies in Birmingham are faced with the difficulty of providing nurses to work over new areas, and the need is urgent'. The Birmingham Society formed in 1927 a special sub-committee to consider the needs of the unprovided areas. The report of this committee urged the need for extending nursing services to cover the whole area of the City, and for arranging amalgamation or co-operation between the societies working in that area. The Society adopted this policy and entered into negotiations with most of the other Societies. As a result of these negotiations the City of Birmingham District Nursing Association was formed at the beginning of 1929 by the amalgamation of six societies, namely Birmingham, Acock's Green and District, Hay Mills and South Yardley, King's Norton, Sturchley and Cotteridge, Selly Oak and

Bournbrook, and Handsworth In 1931 three more societies were included—Billesley, Erdington, and Sparkhill and Greet, and King's Heath joined in 1932. There still remain three district nursing societies in Birmingham other than the Association—Harborne, Aston Manor, and Selly Park and Dad's Lane Estate

The above is a summary of the history of the Birmingham Society up to the time when it became merged in the City of Birmingham Association What follows is a description of various aspects of the work and organization of the Association, and to a lesser extent of the three other societies, as the position was in 1934

#### GENERAL ORGANIZATION

The City of Birmingham District Nursing Association now covers the whole City area with the exception of the areas covered by the three other societies (There are two minor exceptions to this statement (1) In Stechford there is a visiting nurse who works for those subscribing in a membership scheme (2) There is a separate District Nursing Society in Rubery which includes that part of Rubery which falls within the City area )

The Association employs (in 1934) 77 nurses and the three other societies employ 7 between them Thus there is a total of 84 nurses working in the City (All the figures given for nurses include superintendents )

That part of the City covered by the Association is divided into eleven areas, each with its own Area Council. The areas are:

Acock's Green  
 Billesley and Yardley Wood  
 Bordesley, Balsall Heath, and Moseley  
 Central and Winson Green  
 Erdington  
 Handsworth and Perry Barr.  
 Hay Mills, Yardley, and Small Heath  
 King's Heath  
 Saltley and Washwood Heath  
 Selly Oak, King's Norton, and Northfield.  
 Sparkhill and Greet

With some re-adjustments the Central, Bordesley, and Saltley areas are the areas covered by the old Birmingham Society and the other areas those covered by the other societies

The number of nurses employed varies from 17 in the Central area down to two in Billesley and in King's Heath. In most of the areas the nurses live in Homes under the direction of a superintendent or nurse-in-charge. This arrangement is much preferred by the Association and efforts are being made to adopt it when circumstances permit in the areas where at present there are not Homes, namely, Acock's Green, Billesley, King's Heath, and Selly Oak

The advantages of Homes are many. Much more adequate and suitable accommodation can be provided for the nurses than in the majority of lodgings (e.g. hot baths and facilities for drying clothes). The cost of maintenance per nurse is less. The nurses work under the direction of a superintendent or nurse-in-charge, who can give advice and suggestions whenever necessary. (This service has been extended to a certain extent to the areas without Homes by the appointment, at the time of the amalgamation, of a supervisor for outlying areas.) The social life of the Homes and the stimulus of contact with those doing similar work are also advantages to the nurses.

All the Homes with superintendents take candidates for training. These candidates are State Registered Nurses who have already had three years' hospital training, and who are given six months' training in district work at the Homes. At the end of this time, if they pass the necessary examinations, they become Queen's Nurses. The candidates are of two types—'Staff Candidates' who apply direct to the Home and promise to work for the Association for a year after completing their training, and candidates sent by the Queen's Institute. All the Homes with superintendents take Staff Candidates, but only the Central Home takes Institute Candidates.

The Association is affiliated to the Queen's Institute and is regularly inspected by it. Practically all the nurses employed are Queen's Nurses. (Of the three other societies, two—Selly Park and Aston Manor, are affiliated to the Institute.) The nurses employed by the Association therefore come under the salary scale and general conditions of work of Queen's Nurses throughout the country, and there is nothing special to note,

except with regard to the pensions scheme. In 1931 the Association joined the Federated Superannuation Scheme for Nurses and Hospital Officers, which covers nearly all the staff employed. The Association also contributes to the Queen's Institute Long Service Fund for those nurses who are too old to benefit by the Federated Superannuation Scheme.

### AMOUNT OF THE NURSES' WORK

In 1934 the Association's 77 nurses attended 10,330 cases and paid 345,451 visits. This gives an average of 134 cases and 4,488 visits per nurse. The average number of visits per case was 33. (In addition one nurse in the Central Area attended the General Dispensary Dental Clinic for three mornings a week, and one nurse in the Selly Oak area attended every morning at a factory.)

Between 1932 (when the last of the present constituent societies joined the Association) and 1934

the number of nurses increased by 5,

the number of cases increased by 1,888,

the number of visits increased by 55,630.

If we compare the position in 1934 with that in 1927, seven years earlier, we find that in 1927 the nine societies then existing which have joined the amalgamation employed 44 nurses—so that since that date the number has been increased by 33. (The total number of nurses employed by the three other societies was seven at both dates.)

In the area formerly covered by the Birmingham Society the number of nurses has increased in this period from 31 to 43. In some of the outlying areas the proportionate increase has been much greater. For example, Hay Mills has increased from 1 nurse to 8, Acock's Green from 1 to 3, Erdington from 3 to 6, Handsworth from 2 to 4. There is no doubt that the amalgamation has helped to increase greatly the amount of work done, especially in the outlying areas. In the first year of the amalgamation nine additional nurses were appointed.

### IS THE SERVICE ADEQUATE ?

Let us start with a comparative view. 'All these arrangements secure to the citizens of Birmingham one of the best

nursing services throughout the country' says the report of the Queen's Institute on its inspection for 1934. This statement is borne out by the 'Survey of District Nursing in England and Wales,' published by the Queen's Institute in Autumn 1935. According to the figures in this Survey, out of the fifteen County Boroughs with a population of over 200,000, Birmingham stands fifth in the list in the number of nurses in proportion to population, it is surpassed only by Leicester, Bristol, Cardiff, and Leeds (in that order of merit). It has a service considerably more adequate than the two cities nearest to it in size of total population—Manchester and Salford, and Liverpool. At the time of the Survey, Birmingham, with a total population of 1,003,000, had 88 nurses, 1 per 11,393 of population, Manchester and Salford, with a total population of 990,000, had 71 nurses, 1 per 13,941 of population (and midwifery as well as general nursing was undertaken), Liverpool, with a total population of 856,000, had 57 nurses, 1 per 15,012 of population.

But while Birmingham has a very good service in comparison with other places, both the Association and the Queen's Institute realize that the number of nurses ought to continue to increase. In the 1934 Report of the Association is the statement that 'The General Council entirely accept the statement of the Queen's Institute that more nurses are still required in the City.' According to the Survey referred to above, Birmingham requires an additional number of 39 nurses, making a total of 127, in order that the service shall be adequate—this number would give roughly 1 nurse per 7,900 of population. At the time of the amalgamation the Committee of the Birmingham Society estimated that a total of at least 120 nurses would be needed to cover the City.

The need for more nurses does not, of course, imply that the existing staff are desperately overworked. Overwork sometimes occurs and, if it continues for long, the situation is met by the appointment of another nurse in that area. But the unsatisfied demand is not necessarily so vocal. Experience seems to show that the more nurses employed, and the smaller the districts of each nurse, the more cases are obtained, that is to say, that additional nurses 'make their own work.' People see the nurse going about the district and hear of her

services to neighbours, and they are thus stimulated to ask for her in cases where they would previously have tried to manage without expert help. The coming of the Contributory Scheme has advertised the work of district nurses among many people who previously did not think of themselves as those for whom the service was intended—it is ceasing to be regarded as a service only for 'the poor'.

The problem of adequate provision is, of course, much complicated by geographical considerations. Where small societies exist there may well be, for example, work for more than one nurse but not enough work for two. The amalgamation has greatly lessened this difficulty by grouping the City into fairly large areas, each covered by several nurses, usually living together in a Home. (The arrangement of areas in the South of the City would become much easier if the Harborne and Selly Park Societies, in particular the latter, could see their way to joining the amalgamation.)

The grouping of districts has, however, the disadvantage that much time and energy must be spent by the nurses in travelling, especially in sparsely populated areas and on the new housing estates. (An extreme example of this was given me by an officer of the Erdington Area, who estimates that the nurses working on the Kingstanding estate must at present cycle about 16 miles a day.) The remedy is presumably the provision of more cars. The nurse at Northfield has a car, with which she covers also Bantley Green and Quinton, but this seems to be the only car used by a nurse under the Association. (In the case of both the Harborne and the Selly Park Societies the nurse uses a car.)

## FINANCE

### A GENERAL COMPARISON OVER THE LAST 40 YEARS.

As was mentioned above, there has been a very great change in the nature of the finance of district nursing during the course of its history. This will be seen clearly from the following table, which compares the proportions of income raised from different sources in the years 1894, 1904, 1914, 1924, and 1934. For the first four dates the figures refer to



the Birmingham Society, for the last date they refer to the City of Birmingham Association.

**BIRMINGHAM DISTRICT NURSING SOCIETY AND ASSOCIATION  
SOURCES OF INCOME, 1894-1934**

	1894	1904	1914	1924	1934
	£	£	£	£	£
<b>Total Ordinary Income</b>	<b>792</b>	<b>1,900</b>	<b>2,116</b>	<b>4,487</b>	<b>17,709</b>
<i>Proportion of Ordinary Income from</i>	%	%	%	%	%
General Subscriptions and Donations	39	61	46	29	17
Grants from Local Charities	58	34	22	25	5
<i>Total Charitable Gifts</i>	<i>97</i>	<i>95</i>	<i>68</i>	<i>54</i>	<i>22</i>
<i>Interest</i>	<i>1</i>	<i>1</i>	<i>8</i>	<i>5</i>	<i>3</i>
Individual Patients' Contributions		1	4	22	5
Grants from Public Authorities	1	2	3	11	7
Approved Societies				3	3
Hospitals Contributory Scheme					55
Other Benefit Schemes					4
Payments for Factory Nursing	.		5		
Training Fees			10	3	1
<i>Total Payments for Services Rendered</i>	<i>1</i>	<i>3</i>	<i>22</i>	<i>39</i>	<i>75</i>

This comparison brings out several interesting points, of which the most striking are —

(1) The very great growth of total income. The 1934 figure is not comparable in this respect, as it refers to the amalgamated Association, but in the 30 years, 1894-1924, total ordinary income multiplied more than 5½ times.

(2) The steady drop in the proportion of income from charitable gifts and the concomitant rise in the proportion of payments for services rendered.

(3) The small proportion of income from interest.

I will now discuss some of the items of income in more detail.

#### INTEREST AND ASSETS

The Association receives a very small proportion of its income in interest on investments and bank deposits. The total amount in 1934 was £522—3 per cent. of total ordinary income.

The Liverpool Association presents a great contrast in this respect—in 1934 24 per cent of its income came from interest. In the Manchester and Salford Association the contrast is less, but is still great—in the year 1933-4 13 per cent of its income was from interest.

The bulk of the assets of the Birmingham Association are in the buildings and equipment of the Homes. Only about £13,000 of its £45,000 of assets is in investments and cash. Liverpool has over £50,000 of assets in these forms.

There is record of 47 legacies left to the Association and its constituent societies during the course of their history, to the total value of about £10,000. Of these legacies one was for £1,500, two for £1,000, and the rest for £500 or smaller sums. There have also been several large gifts, mostly for the building, extension, or equipment of the Homes. But I was informed by one officer of long experience that nursing has never 'caught on' in Birmingham, as it has in some places, as a receiver of large subscriptions. This fact probably partly accounts for the inability of the Birmingham Society in the past to build up any large reserve funds, and for its very precarious financial position at several periods.

#### GENERAL SUBSCRIPTIONS AND DONATIONS

These appear to the ordinary person as the hall-mark of a voluntary charitable organization, so their nature and history is particularly interesting.

In 1894 the £296 given in annual subscriptions (only £15 was given in donations) was given by 292 persons. Of these the majority were presumably fairly well-to-do, as only 29 of them subscribed less than ten shillings and 124 subscribed a guinea.

In 1904 the number of subscribers had risen to 514, contributing £720, and donations had risen to £111. Also, as has been described above, the Ladies' Auxiliary Fund had been organized two years earlier, and had been very successful in collecting subscriptions, many of them small, by house-to-house collections. In that year they made a grant of £388 to meet the Society's deficit.

In 1914 both the number and amount of the ordinary subscriptions had dropped—to 453 persons contributing £663.

—and donations had also dropped. But the Ladies' Auxiliary Fund continued to flourish.

In 1924 the position with regard to subscriptions was rather better—457 persons contributed £716—and donations had much increased. The Ladies' Auxiliary Fund continued to contribute generously, and included in extraordinary income was £451 raised by a Flag Day.

The Ladies' Auxiliary Fund had separate accounts and published a separate Annual Report. In 1926 its 111 voluntary collectors collected £436. Its Report for that year gives lists of 2,291 contributors of one shilling and upwards, and there were also appreciable sums collected in amounts smaller than one shilling. Its very successful methods have been continued in the present house-to-house collections of the Area Councils.

The present position (1934) may be summarized as follows.

The total amount of ordinary income received in direct charitable contributions was £2,961. This does not include the £767 given in charitable contributions to the Extension Fund, of which £657 was raised by the Flag Day.

The Central Fund received in subscriptions, collections, and donations £517. Four-fifths of this was in subscriptions given by 224 individuals. By the amalgamation agreement this amount is divided between the three Area Councils which cover the area of the old Birmingham Society: 51 per cent goes to the Central Area, 37 per cent to the Bordesley Area, and 12 per cent to the Saltley Area.

The rest of the direct charitable gifts of the public are collected by the Area Councils. A total of £1,946 was raised in the areas from subscriptions and collections, £301 from donations, and £198 from sundry receipts and appeals, e.g. whist drives, dances, concerts, garden parties.

A great deal of the sum raised in the areas in subscriptions and collections was raised by house-to-house collections, mostly in fairly small amounts. The figures for these collections are very striking. Excluding the Billesley Area, where details of the collections are not given, the other areas give lists of all those subscribers who contribute either 2s. 6d. and over or 1s. and over. The following table gives details

of the number of contributors and the number of collectors in the different areas (I have included the figures for the Selly Park Society, where the system of collection is the same) The table also gives the total sums raised in subscriptions and collections in the different areas--in some areas this includes

HOUSE-TO-HOUSE COLLECTIONS FOR DISTRICT NURSING IN BIRMINGHAM,  
1934

	Amount of Subscriptions and Collections	Number of Contributors to House-to-House Collections		Number of Collectors
		Amounts of 2s. 6d and over.	Amounts of 1s and over	
Acock's Green	102	241		40
Billesley	34	?	?	12
Bordesley	144		767	44
Central	54		311	16
Erdington	240	..	1063	80
Handsworth	334	934	..	69
Hay Mills	252		2050	130
King's Heath	88		338	22
Saltley	256		335	23
Selly Oak	266	769	..	66
Sparkhill	176		1433	77
Total Association	1946	1944	6297	591
		8241		
Selly Park Society	95		706	44
Total Birmingham	2041	1944	7003	635
		8947		

other sums besides those raised in the house-to-house collection The number of contributors given includes only those individually listed, but in addition quite considerable sums were collected in individual amounts of less than 2s. 6d. or 1s.

The table shows that at least 8,950 persons contributed to

district nursing through the house-to-house collections. If it were possible to include the number of those not individually listed the total would be much greater, but it is very impressive as it stands. It is obvious that the service makes a very wide appeal to the generosity of all kinds of people, many of whom support it regularly year after year.

The collection of these contributions is made possible only by the work of the 635 voluntary collectors. Some of these have very long records of service—a report from the Bordesley area speaks of workers who have collected with unfailing regularity for twenty years.

As compared with the position two years ago, in 1932, (when the Association first included all its present areas) the total amount of ordinary income received by the Association in direct charitable contributions is greater by about £150. There was a drop in sundry receipts and appeals and in subscriptions to the central fund. On the other hand the subscriptions and collections in the areas were greater by over £200. In some areas it is only a shortage of collectors that prevents more from being collected. These facts seem to show that, though the coming of the Hospitals Contributory Scheme may sometimes have led individuals to discontinue or reduce their charitable contributions, there has been no general effect of this kind.

#### GRANTS FROM LOCAL CHARITIES

The total amount received in 1934 in grants from local charities was £835—5 per cent of ordinary income. The most important grants have been those from the Birmingham and Midland Counties Training Institution for Nurses up to 1909 (as described above), the Hospital Saturday Fund, the Hospital Sunday Fund, the Birmingham General Dispensary, and several endowed charities. (Several area councils also receive grants from endowed charities in their districts—these grants are included in the figures for area donations given above.)

In 1934 for the first time a grant (amounting to £237) was received from the charitable fund derived from a proportion of the profits of Sunday entertainments, paid under legal requirements.

## PAYMENTS FOR SERVICES RENDERED

## INDIVIDUAL PATIENTS' CONTRIBUTIONS

The amount of these in 1934 was £950, £52 of this sum being fees from private patients

In the case of private patients, amounts up to 3s 6d a visit seem to be charged. There is considerable variation between different districts as to the amount of this work done, as some districts are much better supplied with private nurses than others.

Of the ordinary cases a large number do not give any individual contributions. All members of the Hospitals Contributory Scheme are treated free (though I was told in one area that they are quite encouraged to give extra donations if they wish). The coming of the Scheme has therefore meant the loss of a certain amount in individual contributions. Cases coming under the Public Assistance Committee and under the Birmingham General Dispensary are treated free in return for grants from these bodies.

Cases not falling into any of these classes seem to be charged (or not charged) according to the discretion of the nurse, in consultation with the Superintendent (in areas with a Home). Many cases still have to be treated free, e.g. unemployed persons who have fallen out of the Contributory Scheme. The Association has no means of enforcing payments, and their collection depends very much on the tact of the nurses.

## GRANTS FROM PUBLIC AUTHORITIES

Public grants to district nursing associations are authorized for certain special purposes. Some of these possible grants are for work which in some places is done by district nursing associations, but which is not done by them in Birmingham, e.g. infant welfare health visiting, and midwifery. There remain two types of public grant which are given in Birmingham as well as in many other places, and a third type which is given in Birmingham and which, as far as I know, is most unusual.

(1) The oldest grant from the Local Authority is that given originally by the Board of Guardians and, since the 1929 Local

Government Act, given by the Public Assistance Committee. It is given to aid the nursing of Poor Law cases. In Birmingham it has always been a fixed grant, not varying directly with the number of cases nursed.

The first grant to the Birmingham Society was 10 guineas from the Birmingham Guardians in 1892. The Aston Guardians followed in 1900 with a grant of 15 guineas, and the King's Norton Guardians in the same year with 5 guineas. In 1901 the Birmingham Guardians raised their grant to 20 guineas. In 1909 all three Boards raised their grants, making their total 55 guineas, and, when the Birmingham Union was reconstituted to include Aston and King's Norton, this total grant was continued by the Birmingham Guardians. From 1921 to 1924 the grant was £100, and from 1925 to 1928 £250. Meanwhile grants were also being made to some of the other societies in Birmingham.

Since 1930 the Public Assistance Committee has made an annual grant of £285 to the Association. In 1934 it also gave grants of 5 guineas each to the Erdington, King's Heath, and Sparkhill Areas, and grants of 5 guineas each to the Harborne, Aston Manor, and Selly Park Societies. Thus the total contribution of the Public Assistance Committee to district nursing in Birmingham was in 1934 £316 10s.

This grant does not claim to cover the whole cost of nursing Poor Law cases. The amount can be revised on the application of either party.

(2) The second type of public grant is that given by the Public Health Committee to all the district nursing associations in Birmingham for the nursing of certain specified diseases. Mention was made above of the beginning of this work. In the last five years the total number of such cases nursed by the Birmingham associations has varied between 789 and 1089 a year. In 1934, out of 896 cases nursed, 839 were cases of pneumonia, and the other 57 were cases of measles, whooping cough, and puerperal pyrexia. (Cases of ophthalmia neonatorum, which in some places are nursed by district nursing societies for Public Health Departments, are in Birmingham dealt with by the Eye Hospital, which receives a grant for this purpose from the Public Health Committee.) For all these cases nursed by the district nursing societies a grant is made of £1 per case—

an amount which is probably about equivalent to the cost. The grant was originally not so much •

(3) The third type of public grant is the 'City of Birmingham Borough Fund and Rate Grant' given annually to the Association. The grant was first given in 1920, when it was £40 two years later it was raised to £80, and has remained at this figure ever since. The grant is given under a clause in the Municipal Corporation Act which empowers a corporation to give a grant in return for services rendered to its servants. It is thus a grant given by the Birmingham Corporation as an employer in return for the services of the district nurses to its employees. As far as I know, this type of grant to a district nursing society is very unusual.

The total public grants to the Association in 1934 amounted to £1,294—7 per cent of its ordinary income

#### APPROVED SOCIETIES

The subject of payments from Approved Societies has been dealt with in the historical account above

#### THE HOSPITALS CONTRIBUTORY SCHEME

Both the finances and the organization of district nursing in Birmingham have been greatly affected by this scheme. The scheme provided in 1934 a total of £9,790 for the Association—55 per cent of its ordinary income. From the beginning of the scheme in 1928, district nursing was included as one of the services benefiting. From that date up to the end of 1934 £53,500 has been paid to district nursing societies in Birmingham and the surrounding district—3·2 per cent of the total disbursements of the scheme. In 1934 the sum paid for nursing was 4 per cent of disbursements. This means roughly that the members of the scheme (who contribute 3d per week) are getting the service of district nursing free for themselves and their dependants for about ½d a week or 6½d a year.

The scheme originally paid for nursing services at a fixed sum per visit to members, but latterly, instead of this arrangement, it has paid to district nursing associations the same proportion of their costs of treating its members as it pays to the hospitals. (The three other societies in Birmingham



participate on the same basis as the amalgamated Association.) In 1934 the average cost per Contributory Scheme patient nursed by the Association was £1 18s 3d, and the average cost per visit was 11.5d. The Scheme paid 86 per cent of this cost.

This arrangement is evidence of the appreciation which both the Scheme and the hospitals feel for the work of the district nurses. 'The knowledge that expert After-care treatment is available is of the greatest assistance to Hospital authorities, who are able to discharge patients earlier than might be possible otherwise,' says the latest Report of the Contributory Association, referring to one of the advantages of co-operation.

The Scheme extends over the whole area of Birmingham (and beyond), and its coming has much increased the demand for nurses in some districts. It was one of the factors leading to the amalgamation in 1928, and to the consequent effort to cover, or to cover more adequately, the outlying areas of the City. In return for this increased service the Scheme has tremendously improved the financial position of the Association. In fact I get the impression that there is now no serious financial obstacle to the Association extending nursing services as much as may be required.

#### GENERAL CONCLUSIONS ON FINANCE

The table of sources of income over the last forty years shows a progressive and tremendous change in the relative proportions contributed by charitable gifts and payments for services rendered. This change is much greater in district nursing in Birmingham than in the same service in many other places, because of the success of the Contributory Scheme, but to a lesser extent it is true of district nursing in general. This suggests a reflection on the change in the function of charitable gifts. The function of charity proper has changed from that of paying the whole cost of the service for those too poor to help themselves in any way to that of meeting the difference between the cost and what those benefiting can afford to pay, either individually or through mutual insurance. It follows that a given sum of money in charitable gifts 'goes much further' in the sense that it now subsidizes a

large amount of service instead of paying the whole cost of a small amount (This statement is an exaggeration, as there are still many cases too poor to pay anything, but it describes the position with regard to the majority of the cases nursed)

Charitable donations are still very important in order to finance extensions of work and capital expenditure. The proceeds of the annual Flag Day are devoted to building or extending nurses' Homes. The Association will require at least three additional Homes in the near future, and requires a reserve of £10,000 for this purpose

### THE VOLUNTARY PERSONNEL AND ITS WORK

In district nursing, in contrast to a good many other forms of social service, there is practically no scope for the voluntary worker to participate in the actual service rendered. It is obviously necessary that nursing should be done by skilled, trained persons who make it their professional occupation. The only exception to this has been the supplementary work of members of the St. John Ambulance Brigade from 1915 to 1923. This has not occurred as a regular arrangement since that date, but the Association occasionally enlists the services of a voluntary nurse at times of great pressure.

There are three ways in which voluntary workers are concerned in the running of district nursing in Birmingham.

1 In the rendering of certain supplementary services to patients

2 In collecting funds

3 In the administrative work of honorary officers and committee members

#### I SUPPLEMENTARY SERVICES VOLUNTARY VISITING

As was mentioned above, there was a period in the history of the Birmingham Society when voluntary visitors went round to cases with the nurses at various intervals. This has not occurred in the Birmingham Society since 1901, but it has occurred more recently in some of the other societies. There are now no voluntary visitors of this kind in any of the areas of the Association, but they still continue in the Harborne Society.

Several factors have probably contributed to the discontinuance of the practice. In some cases the visitors were very undependable and irregular. They tended to embarrass the nurses. The raising of the standard of nursing, the grouping of nurses in Homes under Superintendents, and the regular inspections of the Queen's Institute have meant that any sort of professional supervision of the nurses' work by committee members has become unnecessary, and also that such supervision would be of a kind which amateurs would be quite unqualified to give.

Another function of the early visitors was to investigate whether any supplementary relief was necessary. Any points of this kind can now, in most cases, be referred by the nurse to the Superintendent. The Association does very little itself in the way of relief, except the provision or loaning of nursing requisites, but the Superintendent refers cases in need of relief to the appropriate public authority or voluntary agency.

Thus, under present conditions, there is no direct connection between the voluntary organizers and supporters of district nursing and the patients whom they benefit.

## 2 THE COLLECTING OF FUNDS

It has been shown above that there are nearly 600 people helping in the house-to-house collections for the Association. Some of these people are also committee members but many are not. There are also the voluntary helpers at bazaars, concerts, etc., and at the annual Flag Day. We should also remember that the work of the Hospitals Contributory Scheme involves a very large number of voluntary workers—the number was estimated in 1933 as 9,450. The work of these collectors of funds is very little in the limelight but it is of great importance.

## 3 THE WORK OF HONORARY OFFICERS AND COMMITTEE MEMBERS

(a) *The number of committee members*—The work of each of the 11 areas of the Association is controlled by an Area Council. These councils vary in size from 36 to 14 members. The total number of members of Area Councils is 201 (including officers).

The Selly Oak Area (which combined the districts of two former societies) has, besides its Area Council, three District Committees, and there are 13 members of these Committees who are not on the Area Council. This makes the total of council and committee members in the Association 214.

The three other societies have about the following number of committee members: Harborne 16, Aston Manor 29, Selly Park 24.

Thus the total number of committee members administering district nursing in Birmingham is about 280-290.

(b) *The organization of committees*—In all the areas of the Association with Homes (that is in 7 out of the 11 areas) there are sub-committees of the Area Councils, known as House Committees, controlling the Homes. The membership of these House Committees is entirely female. In two other areas there are small Executive Committees. The membership of these sub-committees varies in different areas between 8 and 4.

Aston Manor Nursing Institution (which has a Home) has a sub-committee of all the women members of the general committee.

The other Area Councils and societies apparently have no separate executive committees.

The General Council of the Association has a membership of 61, including representatives of all the Area Councils, elected by them on a basis laid down in the laws of the Association. It also includes representatives of contributors of 10s and upwards, the officers of the Association, a certain number of co-opted members, and representatives of the Public Assistance Committee, the Birmingham General Dispensary, and the Hospital Saturday Fund.

The Executive Committee of the General Council has a membership of 19—the 4 officers, 1 representative from each Area Council, and 1 representative from each of the four Standing Committees.

The intervals at which committees meet vary from district to district, the usual intervals are monthly, bi-monthly, or quarterly.

(c) *The nature of the work of committees and officers*—The work of the committees is concerned partly with raising funds and partly with general administrative problems. The kind of

work of both the committees and the honorary secretaries varies considerably as between the districts with Homes and the districts without them

In the districts with Homes the day-to-day supervision of the nurses' work falls on the Superintendent or Nurse-in-Charge. There is no contact between the honorary officers or committee members and individual nurses. The administration of the Home is in the hands of the House Committee, leaving the general council or committee for the district to deal with the raising of funds and any very general problems of policy.

In the districts without Homes the general council or committee (unless there is an executive) deals with all the questions which arise. There is a great deal more work for the honorary secretary, as the nurses will frequently consult her and report to her (or him) in the absence of a superintendent. (In the districts under the Association the supervisor for outlying areas relieves honorary secretaries of a good deal of this supervision on the professional side.)

(d) *The personnel of committees*—First with regard to sex, the great majority of committee members are women. On the Area Councils and committees of the Association there are 185 women and 29 men, and the Area Councils of Accock's Green and Handsworth are entirely female. On the committees of the three other societies there are 43 women and 26 men, most of the men being on the committee of the Aston Manor Nursing Institution.

The time of day at which meetings are held and the nature of the personnel have a reciprocal influence. Committees which include men are often obliged by that fact to meet in the evening. On the other hand, the House Committees usually meet in the morning. It should be noted that this time of meeting excludes not only men but also women who are, as the Census expresses it, 'gainfully occupied'.

District nursing associations, in Birmingham as elsewhere, have evoked a large amount of unobtrusive, devoted service from officers and committee members, often over a long period. For example, the Birmingham Society had the same honorary secretary for 29 years.

There seems to be very little competition for election to

committees Nearly all the district councils and societies hold annual meetings, which all those subscribing to the funds are entitled to attend (Sometimes subscribers are circularized directly and sometimes the meeting is more generally advertised) But although, as was shown above, the number of subscribers in many districts amounts to several hundreds, the attendance at annual meetings is almost always pretty poor One example will suffice--a district with over 700 subscribers of 2s 6d and upwards gets an attendance of 25-40, although all these subscribers are individually notified (The one district which is an exception is the Handsworth Area, where for several years there was an attendance of 70 The Honorary Secretary of this Area is of the opinion that subscribers are attracted by the fact that there is an opportunity given to visit the Nurses' Home after the meeting) The officers and committee members are usually elected by these meetings without any contest, and there never seem to be any suggestions of candidates for election made from the body of the meeting

It is rather surprising, in view of the tremendous change in the sources of income of district nursing in Birmingham, that there are hardly any working-class members of committees (at any rate in the districts for which I have information), though many of the collectors are working-class Besides the large amount coming from the Hospitals Contributory Scheme, whose members are mainly working-class, a large number of the small charitable subscriptions must come from working-class households District nursing has ceased to be, as it once was, financed by the comparatively well-to-do, but it continues to be administered by them

### THE HARBORNE, ASTON MANOR, AND SELLY PARK SOCIETIES

It remains for me to describe the organization and activities of the three district nursing societies in Birmingham which have not joined the amalgamation, in so far as these have not been already covered

*The Harborne District Nursing Society* is the oldest of the three: it was founded about 1891.

In 1933-4 it employed one nurse, who used a car, and who attended 140 cases and paid 4,582 visits. It used to employ two nurses.

In the year 1933-4 the Society had a total income of £452 and a total expenditure of £258.

The main items of income were £21 in patients' payments for attendances, £5 in interest, and £368 in subscriptions and donations. This last sum included a grant from the Public Assistance Committee and from a local endowed charity, sums from entertainments and from the Flag Day, and £71 in subscriptions from 165 individuals. There does not seem to be any organized house-to-house collection, but a considerable number of the subscriptions are for 5s, 2s 6d, and other small amounts.

*The Aston Manor Nursing Institution* was founded in 1899. As was mentioned above it was started with the proceeds of a fund raised in Aston Manor for nursing on the occasion of the Diamond Jubilee. A Home was established at the start and the Home has at present 1 Matron and 4 nurses. An additional nurse has been appointed since the coming of the Contributory Scheme. The Institution affiliated to the Queen's Institute in 1937.

In 1934 the nurses employed by the Institution attended 606 cases and paid 18,239 visits.

In that year the total income of the Institution was £1,070, and its total expenditure £1,102. The assets of the Institution amounted to £8,332. The Institution is in a very good financial position.

Of the income nearly half (£519) came from the Contributory Scheme. The Institution received public grants of 5 guineas from the Public Assistance Committee and £41 from the Public Health Committee. Fees and donations from patients amounted to £31. No regular charge is made to patients, and in most cases they are either members of the Contributory Scheme or are treated free, as the district is a very poor one. There was an income of £250 from interest and rent—nearly a quarter of the total income. The other items of income were Flag Day receipts, and £176 in subscriptions and donations, including local charities. Subscriptions amounted to £66 from 54 individual contributors.

and £24 from the employees of two works. There are no house-to-house collections, and most of the subscriptions are in amounts of 10s or more.

*The Selly Park and Dad's Lane Estate District Nursing Society* was founded in 1906. It was originally known as 'The Selly Hill, Ten Acres and Dog Pool District Nursing Society.' It was enlarged later to include the Dad's Lane Estate.

The Society is affiliated to the Queen's Institute and employs one Queen's Nurse, who possesses her own car. In 1934 she attended 147 cases and paid 3,855 visits. The Society has enough funds to employ another nurse, and would like to do so, but there is not enough work for her.

The total income of the Society in 1934 was £414, and its total expenditure £273. It has £1,000 of assets which have been built up in the last six years or so.

Of the income £164 came from the Contributory Scheme, and £55 was in other payments from or on behalf of patients, including payments from Approved Societies and from the Public Health Committee. The Public Assistance Committee gave a grant of 5 guineas, there was £27 in interest, and £45 was raised by a dance and by the Flag Day. Subscriptions and donations amounted to £122, of which £95 came from the house-to-house collection. As was shown above, there were 706 individual contributors giving 1s and upwards, as well as contributors of smaller sums. Every road in the area covered has been collected by the Society ever since it started, and, in 1934, 44 collectors participated.

#### PROBLEMS OF AMALGAMATION

The City of Birmingham Association has tried to combine the advantages of some degree of central administration and finance with the advantages, possessed by the previous small societies, of local interest and of administration on a manageable scale. The creation of Area Councils has meant that the committee members of the old societies have continued to participate in the administration of the Association. The arrangement by which the Area Councils are responsible for the collection of funds within their districts has meant that local interest in money raising has been retained. In every



case of a society which has joined the Association there are now more nurses working in its area than when the society was independent, and the figures given above show that in the last three years subscriptions and collections in the areas have increased by £200. Thus the general effect of the amalgamation has been both to increase the amount of the service in all localities and to stimulate local money raising. But, although each area is encouraged to raise as much money as possible, the advantage of a large Association on the financial side is that the poorer areas can be subsidized by the richer, and the resources of the whole City used for the whole City. Many of the items of income are collected centrally by the Association, and its earlier method of grants from the central fund to areas on a fixed basis has given place to an apportionment in relation to the needs and resources of the area in question at the moment. The possibility of meeting an increased demand for nurses in any area depends on the financial position not of that area but of the whole Association.

It is possibly this policy of a large measure of pooling of resources which is one of the factors in deterring the remaining independent societies from joining the Association. There is a conflict between a community of interest in a small district and a community of interest over the City as a whole. With regard to the pros and cons of amalgamation, in so far as these societies are concerned, it seems regrettable that the Selly Park Society in particular should not join the Association. Its methods of work and organization are very similar to those of the Association, and its co-operation would make it possible to organize the South of the City much more effectively. Aston Manor is probably a large enough unit to work effectively independently, but even in the case of this society the Association would offer it certain advantages of large scale organization (e.g. participation in a pensions scheme for all its nurses) which it does not enjoy at present.

## CHAPTER XIV

### DISTRICT NURSING IN A SMALL TOWN—BANBURY

#### GENERAL DESCRIPTION OF BANBURY

BANBURY is situated in the extreme north of Oxfordshire, and is on the Great Western Railway line from London to Birmingham. Its main economic function is that of market centre for the country district surrounding it. It has several factories and a considerable number of railway workers. It is a Municipal Borough and a Local Education Authority for elementary education.

Its population over the period during which the Nursing Association has existed has been as follows —1871, 11,726, 1881, 12,072, 1891, 12,768, 1901, 12,968, 1911, 13,458; 1921, 13,340, and 1931, 13,953.

#### THE HISTORY OF DISTRICT NURSING IN BANBURY

The history of district nursing in Banbury presents several important contrasts to its history in Birmingham. There has been no problem of a rapidly increasing population and a constantly expanding geographical area, and, partly as a consequence of this, financial difficulties have not loomed so large. The smallness of the whole organization has made possible a closer touch both between the committee members and the nurses and between those members and the patients. The Banbury Association has run a midwifery service for the last 28 years, a branch of work hardly touched in Birmingham. And, lastly, in Banbury the District Nursing Association co-operated with the public authority in the first years of both the school medical service and infant welfare work.

The Banbury Nursing Association was founded in 1875, five years after the Birmingham District Nursing Society. The earliest record available is the Fourth Annual Report for the

year 1879-80 (the Association has always ended its year in March or April) In that year the Association had a committee of 12 members, including the Secretary and Treasurer, and 126 subscribers Its total receipts were £109, these were all in subscriptions and donations, there was no income from interest and no payment from patients One nurse was employed and she attended 110 cases and made 3,400 visits She lived in a house rented by the Association as a nurse's Home

In 1893 the Association affiliated with the Queen's Institute This affiliation continued, with regular inspections from the Institute, until 1904, when a new nurse was appointed who was not a Queen's Nurse, and consequently the affiliation lapsed Since that date the nurses employed by the Association have not been Queen's Nurses, so the Association has not been affiliated directly to the Institute Since 1909, however, it has been connected indirectly through its affiliation to the Oxfordshire Nursing Federation, founded a year previously (The Banbury Association again appointed a Queen's Nurse in 1937, and re-affiliated with the Queen's Institute)

In 1902 the Association gave up its house, and since then the nurses have made their own arrangements about lodgings In 1907 a midwifery service was started, and in 1908 the first arrangements were made for co-operation with the Borough Council in public health work (These developments are described below)

The general nursing work of the Association has gone on very steadily There has never been more than one nurse doing full-time general nursing work, but the one full-time nurse has been helped at various periods by the part-time services of extra nurses, and for three years in the post-War period the Association employed three nurses, one for general nursing, one for midwifery, and one dividing her time between the two branches of work The number of general nursing cases and of visits paid to them has been considerably lower in recent years than in the pre-War period, in 1914-5 there were 155 general nursing cases and 3,500 visits were paid to them, in 1934-5 there were 79 cases and 2,190 visits were paid to them For a short period since the War the Association included in both its general nursing and midwifery work the

village of Drayton, 2 miles west of Banbury, but it is now not included

The Association now employs two nurses, one for general nursing and one for midwifery and maternity nursing. Both the nurses are 'village nurse-midwives' (until 1937, when a Queen's Nurse was appointed). In 1934-5, 136 cases were attended—66 medical, 13 surgical, 48 midwifery, and 9 maternity—and a total of 3,544 visits were paid.

In the Queen's Institute Survey of the adequacy of district nursing throughout the country at the end of 1934, it was estimated that, where the district nursing association combines midwifery with general nursing, one nurse per 5,000-6,000 population is required. On this basis the Survey considered that Banbury needed the additional services of half a nurse to be adequately served. There does not, however, seem to be any local evidence of an unsatisfied demand.

The affiliation of the Association to the Oxfordshire Nursing Federation has been of great value to it, particularly in recent years. Besides distributing certain grants to affiliated associations, and providing them with candidates for new appointments, and with the services of nurses for holiday and emergency duty, the Federation has, since 1927, organized a pensions scheme for the nurses employed in the county. Both the nurses employed by the Association belong to this scheme, the annual premium per nurse is £10, of which the nurse pays £5, the Association £2 10s, and the Federation £2 10s.

#### THE MIDWIFERY SERVICE

Up to 1907 only one nurse was employed. In 1906 the question arose of the desirability of employing an additional nurse for midwifery and maternity nursing. The Midwives Act of 1902 prohibited, after a certain period, the conducting of a confinement by any one except a doctor or a legally registered midwife. This completely changed the existing position, because, prior to the Act, many poor women had been attended by unqualified midwives, who charged only small amounts for their services. The Report for 1906-7 says 'In the past many poor women could well afford to pay small sums in order to secure the services of a midwife,

but they cannot in the absence of any midwife pay the full doctor's fee, amounting usually to a guinea. The Committee believe a certificated midwife is needed in the town of Banbury to work among those who are too poor to pay a doctor. It is felt the nurse cannot be self-supporting, and subscriptions will be needed to supplement the patients' payments. It was decided to engage an additional nurse for midwifery, and in April 1907 the first public annual meeting held for many years was held in the Council Chamber of the Town Hall, when an address was given on the work of trained midwives. The midwife started work in August of that year. In the first seven months she attended 21 cases, and in her first full year—1908-9—she attended 81 cases, so that the new venture was fully justified.

The system of charging adopted in the first years of the service was a mixture of direct payments by patients and payments by subscribers' recommendations. The original fees fixed for midwifery were 10s. when the husband earned under £1 a week, and 15s. when he earned between £1 and 30s. Every subscriber of half a guinea could recommend one woman for the services of the midwife at half the usual rate. Fees had to be paid in advance. Besides paying the difference between the cost of the midwife's service and the amount received in fees the Association guaranteed the doctor's fee if he had to be summoned in an emergency, and quite often had to pay it in the first years of the service. (In certain cases the Poor Law Medical Officer was willing to attend.) The National Insurance Act of 1911, which provided a maternity benefit for insured women and the wives of insured men, very much improved the position with regard to the patient's capacity to pay for midwifery services. 'The maternity benefit has proved a great boon, the mothers pay our charge cheerfully, and the nurses do not have to press for money when, as of old, they felt it was needed for food.' The Association raised its fee to 15s. for all those receiving maternity benefit (except when a doctor was in attendance), and discontinued subscribers' recommendations. (It may be noted that any system of subscribers' recommendations of any kind has been very rare in the history of district nursing.)

In 1909 a second midwife was engaged. This was necessi-

tated partly by the part-time employment of the midwife as school nurse (described below), and partly by the increase in the number of midwifery cases. These increased steadily for the next four years—1909-10, 139, 1910-1, 143, 1911-2, 162, 1912-3, 215. After 1st April 1910 the Midwives Act came fully into force and no uncertified woman could continue to practise. In 1911-2 the Report states that 'The midwifery work has increased owing to the death of some cottage women who have attended their neighbours for many years and our Nurses could not have managed this year without the assistance of a local trained midwife'. In 1912-3 the midwife appointed originally had become engaged entirely in Public Health work, and two other nurses were doing full-time midwifery work for the Association. In 1914-5 one of these nurses set up in the town as an independent midwife, and the Association therefore thought it unnecessary to employ more than one midwife. Only one midwife was employed, with occasional help from other midwives in the town, until the year 1923-4, when an additional nurse was engaged by the Association, to divide her time between general nursing and midwifery. This arrangement continued for three years, when one of the midwives left to take up private work in the town, and was not replaced. Since then only one midwife has been employed, the nurse employed by the Association for general nursing taking cases for her in holiday time and in case of emergency. Since about 1927 the number of midwifery cases attended by the Association has dropped considerably, and has not been above 60 in any one year. This is due partly to the fall in the birth rate and partly to the service of independent midwives available in the town.

The present charges to patients for the services of the midwife vary according to the financial position of the patient. They are usually between £1 5s and £1 10s, but may be as high as £2 2s or as low as 15s, occasionally lower. The charges of the Association are usually lower than those of independent midwives. In the year 1934-5, £77 was received in midwifery and maternity fees, and the salary of the midwife (including allowances) was £144, so that the service is still heavily subsidized by the Association. Since 1922-3 there has been a public grant for midwifery, paid first by the

Ministry of Health, and, since the Local Government Act, 1929, by the Oxfordshire County Council. This grant is paid through the Oxfordshire Nursing Federation. The Federation gets a total grant, of which some is for training midwives, in aid of the salary of the County Superintendent, and for equipment, and the rest is distributed among the district nursing associations in the County. At present there is no fixed basis of distribution, and the grant is allocated after considering all the circumstances of the case. As the Banbury Association, in comparison with many of the village associations, is well off financially and has considerable receipts from midwifery fees, it does not receive a large amount from this grant. The amount in 1934-5 was £6, and in the years since it was first given it has varied from £3 to £7 10s.

### PUBLIC HEALTH WORK

In May 1908, when the Association was employing two nurses, one for general nursing and one for midwifery, the Committee received a deputation from the Medical Inspection Sub-Committee of the Borough Education Committee to ask whether the Association could provide the part-time services of a nurse to be present with the Medical Officer at medical inspections in schools and to follow up cases when required (These duties of the Education Committee were imposed upon it by the Education (Administrative Provisions) Act of the previous year.) The Association consented to lend their midwife for these duties for two afternoons a week at the rate of 15 guineas a year. This arrangement continued for the next two years. In June 1910 the Health Committee of the Borough Council asked whether a nurse could be lent for one day a week to visit cases notified to the Medical Officer under the Notification of Births Act, 1907—a permissive Act which the Council was proposing to adopt. The Association agreed to lend the services of the midwife for 17 guineas a year. Early in the next year the Education Committee increased their requirements to two days a week, and in July 1912 the Council decided to pay for the whole-time services of the midwife as a health nurse, doing both infant welfare and school work, as well as the visiting of notified tuberculosis cases. She

continued to be employed by the Association, and the Council paid £80 a year to the Association for her services. This grant was rather less than the amount of her salary, but it was increased in 1914 to £90, which covered her salary, though it still left the Association with some expenses in connection with her employment.

In 1911 a weekly Mothers' Parlour was opened in connection with the infant welfare work. The health nurse attended, and was assisted by a rota of ladies from the Committee of the Association. The Medical Officer provided the weighing machine and the Association paid the rent of the room and the caretaking expenses. In 1913 the Health Committee of the Town Council took over responsibility for the Mothers' Parlour, and in 1917 the Medical Officer started attending at it. But the Association continued to supply voluntary helpers until after the formation of the Borough Maternity and Child Welfare Committee, which eventually took over responsibility for arranging this.

Throughout the War period the Association provided tickets for food or milk in cases of necessity reported to them by any nurses in the town, and in 1917 it arranged to sell Nestlé's milk and sugar at low prices at the Mothers' Parlour, paying the loss from its own funds.

In 1918 the Town Council arranged for the appointment of a second health nurse. The work was increasing in various directions. At the beginning of the year a school clinic for minor ailments had been started, to be held twice a week and attended by the Medical Officer and the health nurse. The Health Committee was assuming responsibility for visiting children up to five years of age and for supervising cases of measles. Also under war-time conditions a large part of the school attendance visiting was relegated to the health nurses. The second health nurse was actually employed by the Association, but the grant paid by the Town Council to the Association covered her salary and allowances, except for insurance.

Early in 1919 a new appointment had to be made to replace one of the health nurses, and the Association decided to ask the Town Council to take over the whole responsibility for their appointment and employment. A Borough Maternity



and Child Welfare Committee had recently been appointed under the Maternity and Child Welfare Act, 1918, and this committee, unlike the Health Committee, was required by law to include women members. The Council agreed that the time had come for it to take full responsibility, and the Maternity and Child Welfare Committee assumed control in July 1919. The fact that two members of the Committee of the Association were co-opted as members of the Maternity and Child Welfare Committee (one of them becoming its chairman) meant that there was no break in the continuity of development of the work of the health nurses.

Thus the Association performed a very valuable service for the Town Council, both in the early, experimental stages of health nursing, and in the difficult conditions of shortage of labour of the War period. The fact that the first health nurse was already known in the district as a midwife, and in the first years of her health work was also doing midwifery, probably smoothed her way somewhat in the homes she visited on business in which she was not always welcome to parents. (There was a large amount of visiting in connection with 'dirty heads' in the first years of her work.) In later years, when the health nurse was engaged entirely in that work, her association with the general nurse and the midwives as colleagues on the staff of the Association made co-operation with them easy. The development is summed up in the Association's Report for 1919-20: 'We believe that our co-operation for all these years was beneficial but that now we can safely leave this department to a publicly appointed Committee which includes women members. We feel sure that our Nurses will continue to work in close co-operation with the Health Nurses.'

## FINANCE

### A GENERAL COMPARISON OVER THE LAST FORTY YEARS

The following table compares the sources of income of the Association in the years 1894-5, 1904-5, 1914-5, 1924-5, and 1934-5.

The changes in total income are partly the result of the changes in the number of nurses employed, described above.

In 1894-5 and 1904-5 only one nurse was employed, in 1914-5 four nurses were employed—one general nurse, two midwives, and the health nurse, in 1924-5 three nurses were employed—one general nurse, one midwife, and one nurse with combined duties, and in 1934-5 two nurses were employed—one general nurse and one midwife. The effects

**BANBURY NURSING ASSOCIATION**  
**SOURCES OF INCOME, 1894-5 TO 1934-5**

	1894-5	1904-5	1914-5	1924-5	1934-5
	£ 119	£ 141	£ 368	£ 449	£ 331
<i>Total Ordinary Income</i>	%	%	%	%	%
<i>Proportion of Ordinary Income from</i>					
General Subscriptions and Donations	97	73 8	28	24	32 6
Special Efforts				14	
Grants from Local Charities	3	3	4	2	3
<i>Total Charitable Gifts</i>	100	84	31	39	41
<i>Interest</i>		7	7	4	14
Services Rendered by Nurse		17	12	34	20
Services Rendered by Midwife			29	21	23
Public Grant for Midwifery				1	2
Public Grant for Public Health Work			24		..
<i>Total Payments for Services Rendered</i>		17	66	56	45

of these changes in the number of the staff on income show themselves especially in the items of payments for services rendered.

The changes in the number of staff make the general trends of finance less easy to observe than in the case of Birmingham, but, as between the beginning and the end of the forty-year period, it is true, as in Birmingham, that there has been a large decrease in the proportion of income from charitable gifts and a large increase in the amount and proportion of income from services rendered. The extent of this change has, however, not been so great as in Birmingham (compare page

218) for the year 1934-5 the proportions received in the three main groups of income were

Charitable Gifts	Banbury 41%, Birmingham 22%
Interest . . . . .	Banbury 14%, Birmingham 3%
Payments for	
Services Rendered .	Banbury 45%, Birmingham 75%

The main reason for the larger proportion of payments for services rendered in Birmingham is the inclusion there of district nursing in the Hospitals Contributory Scheme

#### INTEREST AND ASSETS

In 1894-5 there was no income in interest included in the balance sheet. There was a reserve fund, but its amount is not given. In 1904-5 there was £4 in interest. By 1924-5 the amount of assets had increased to £485, yielding an income of £20. In 1926-7 the Association received a large increase in its assets on account of the winding-up of the Banbury Visiting Charitable Society. This Society, which was financed partly from endowments and partly from subscriptions, existed 'for visiting and relieving the sick and distressed poor at their own habitations' and, when it was wound up, the Charity Commissioners held that the District Nursing Association was the local charity whose objects were most similar. Since that date, therefore, they have held the endowments previously owned by the Visiting Charitable Society in trust for the Association. In 1934-5 the Association had assets of £1,491 (of which £879 were these endowments), yielding an income of £45.

#### GENERAL SUBSCRIPTIONS AND DONATIONS

In 1894-5 £116 was received in general subscriptions and donations from about 225 subscribers. Four of these subscribers gave 10 guineas each, and 114 gave 2s. 6d. or less, so that even at that date there were a fairly large number of small subscribers.

In 1904-5 £103 was received in subscriptions and donations and the number of subscribers had increased slightly to 231. Of these there were still four giving 10 guineas each, and there were 146 giving 2s. 6d. or less.

In 1914-5 £102 was received in subscriptions and donations from 236 subscribers, of whom four still gave 10 guineas each, and 159 gave 2s 6d or less, so that the position had changed very little during this decade. In the last two decades the actual amount of subscriptions and donations had fallen, and, as total income had risen greatly, the proportion of total income received in subscriptions and donations had fallen from 94 per cent to 28 per cent.

In 1924-5 subscriptions and donations had risen slightly to £107, received from 622 subscribers. During this decade the number of subscribers had more than doubled, but the Association had lost all the four 10-guinea subscriptions.

In 1934-5 the position was almost exactly similar to that ten years earlier, £105 was received in subscriptions from 622 persons.

Two conclusions are clear from this historical comparison.

(1) The actual amount received in general subscriptions and donations has been very steady indeed and there has been no tendency for it to increase with the total income of the Association, any increases of expenditure have had to be met from other sources of income.

(2) Although the amount subscribed has not increased, the number of subscribers has increased greatly—there were between two and three times as many subscribers at the end as at the beginning of the period. It follows that the average subscription has become smaller. This is shown in the two following Tables which compare the position in 1896-7 with that in 1931-2, thirty-five years later. (The Tables include a subscription of three guineas in 1896-7 and five guineas in 1931-2 from the Friendly Medical Association, which has not been included in the above description.) In the earlier year the total number of subscribers is given, in the later year only those subscribing 1s and upwards, as those subscribing less are not included in the printed list.

The Tables show how the balance has changed as between large and small subscriptions. In 1896-7 nearly three-fifths of total income was subscribed in amounts of more than a guinea and over two-thirds in amounts of over half a guinea, while less than 1 per cent was given in amounts of 1s or less. In 1931-2 amounts of over half a guinea accounted for only

BANBURY NURSING ASSOCIATION  
ANALYSIS OF GENERAL SUBSCRIPTIONS AND DONATIONS FOR THE  
YEAR 1896-7

Range of Subscriptions.	Number of Subscribers	Percentage of Subscribers	Total Amount Subscribed	Percentage of Total Amount Subscribed	Cumulative Percentage Downwards	Cumulative Percentage Upwards
Above 10s Go { up to and including } 20 Gns	15	7	£ 73 12 0	58.4	58.4	100.0
" 10s. 6d " 1 "	12	5	12 10 0	9.9	68.3	41.5
" 5s " 10s. 6d	25	11	12 10 6	9.9	78.3	31.6
" 2s 6d " 5s	61	27	15 3 0	12.0	90.3	21.6
" 1s. " 2s 6d.	90	40	11 1 0	8.8	99.1	9.6
1s. . . .	20	9	1 0 0	0.8	100.0	0.8
Under 1s. . . .	2	1	1 0	0.0	100.0	0.0
All Sums . . .	225	100	125 17 6	100.0		

BANBURY NURSING ASSOCIATION  
ANALYSIS OF GENERAL SUBSCRIPTIONS FOR THE YEAR 1931-2

Range of Subscriptions	Number of Subscribers	Percentage of Subscribers of 1s and over	Total Amount Subscribed	Percentage of Total Amount Subscribed	Cumulative Percentage Downwards	Cumulative Percentage Upwards
Above £1 1s { up to and including } £5 5s 6d.	9	2	£ 31 10 6	28.1	28.1	100.0
" 10s. 6d " £1 1s	9	2	9 5 0	8.2	36.3	71.9
" 5s. " 10s. 6d	26	5	13 0 6	11.6	47.9	63.7
" 2s. 6d. " 5s	80	14	19 6 6	17.2	65.1	52.1
" 1s " 2s 6d.	235	42	27 5 6	24.3	89.4	34.9
1s . . . .	204	36	10 4 0	9.1	98.4	10.6
Under 1s	?		1 14 9	1.5	100.0	1.5
All Sums . . . . .	563+	100	112 6 9	100.0		

something over a third, while more than 10 per cent was given in sums of 1s and less, more than a third in sums of 2s 6d and less, and more than half in sums of 5s and less.

#### PAYMENTS FOR SERVICES RENDERED

Payments for services rendered have included over the years listed in the financial table four items—payments for services rendered by the general nurse (or nurses), payments for services rendered by the midwife (or midwives), the public grant for midwifery, and the public grant for public health work. None of these items occurred in 1894-5. Payments for services rendered by nurse occurred in the other four years and there had been some payments in some years before 1894-5. The grant for public health work occurred only during the period when the Association was employing a nurse or nurses as health nurses on behalf of the Borough Council. The payments for midwifery services and the public grant for midwifery have been dealt with above. The total amount in payments for services rendered in 1934-5 was £150-45 per cent of total income.

By far the larger part of the payments for nursing services are payments made by individual cases. Payments are also made by the Poor Law Authority and, in some years, by Approved Societies—these are both made for individual cases, and the amount varies from year to year and is not always included separately in the printed statement of accounts. The Association has never had any provident membership scheme either of its own or in co-operation with any other body. It has considered the matter but is deterred partly by the difficulty of getting a sufficient number of collectors. There is a hospital contributory scheme operating in the town.

*Individual Patients' Contributions.*—In 1934-5 individual patients' contributions amounted to £127-£77 for midwifery and maternity nursing and £50 for general nursing. On the printed reports the following scale of charges for general nursing is included: for a single visit 3s. 6d., if an operation 10s., attendance of nurse per week 10s. 'These payments will not be enforced if the patient is not in a position to pay them.' I am informed that in practice the charge of 3s. 6d.

per visit is a maximum, and that anything down to 6d. per visit is taken. The assessment of the scale of payment is left to the nurse (with occasional consultations with the honorary secretary or committee) and she collects the money. In chronic cases sometimes some other enquiries as to means are made. Some cases are still nursed without any charge at all, but not very many. There are very few private cases requiring the services of the district nurse as the town is well served with private nurses.

*Payments from the Poor Law Authority*—The first payment from the Poor Law Authority to the Association was made in 1899-1900, when the Banbury Board of Guardians made a grant of four guineas 'in recognition of the Nurse's services to the poor of Banbury'. In accepting the grant as a donation the Association stated 'The aim of the Association is to help the independent poor rather than those receiving parish relief, and though we are glad for our Nurse to assist the Guardians in cases of emergency, it must be evident to them that she cannot undertake workhouse cases as a regular part of her work'. The grant of four guineas was continued for the next two years, after which it was dropped. At a committee meeting in 1902 a resolution was adopted that 'As a rule the Association does not attend cases receiving outdoor relief,' the committee to have power to make exceptions.

There the matter rested until 1908 when a letter was received from the Guardians asking on what terms poor law cases were assisted. In its reply the Association stated 'Our District Nurse has never refused to attend any case whether recommended by the poor law doctor or any other doctor that came within the recognized scope of her work and she has generally as many as five names on her books who are in receipt of outdoor relief.' But the reply continues, 'We do not see how it is possible to have any definite agreement with the Guardians because we must reserve our liberty to decide whether cases come under our rules. We feel sure that the Guardians may be satisfied that we do all in our power to help those who are really ill, but as our nurses are fully trained and qualified women, their time is too valuable for attendance on aged and chronic cases for whom a less ex-

pensive nurse would be all sufficient' After consideration the Guardians decided not to give a grant

The next mention in the records of negotiations with the Guardians is in 1919 when the Association decided to ask the Guardians to pay 3s 6d instead of 2s 6d a week for their sick cases nursed by it, a request which was granted Thus at that time the present arrangement existed by which the Poor Law Authority makes a payment per case The Annual Report for 1921-2 states 'There are nine cases for which we receive some payment from the Board of Guardians, but not nearly as much as they would have to pay for a nurse of their own' Since the Oxfordshire Public Assistance Committee has become the Poor Law Authority, the local Guardians Committee has continued the arrangement of the former Banbury Board of Guardians, that is, it pays for its patients according to the amount of work done for them over the period of the grant In the year 1934-5 seven poor law cases were attended and the grant made was £17 Over the five years 1930-5 the annual grant varied between £17 and £46 10s The grant was on account of general nursing services It was probably about equal to the cost of the service

### THE VOLUNTARY PERSONNEL AND ITS WORK

As in Birmingham the Association has received occasional help with nursing from members of the St John Ambulance Brigade In 1933-4 two members of the Brigade and in 1934-5 one member gave help with holiday duty There was also occasional assistance from Red Cross nurses during the War period Except for these instances there has been no use of the services of voluntary workers in the actual nursing work of the Association

### SUPPLEMENTARY SERVICES VOLUNTARY VISITING

From the founding of the Association until the present time there has been a system of voluntary visitors Every month (originally every two months) a member of the Committee acts as visitor Her function is somewhat different from that of the visitors of the Birmingham Society, described



above. The visitors of the Banbury Association have never gone round with the nurses, but have visited the cases on the books to see whether any extra help, in the way of special food, etc., was needed, and in order to keep in touch with the patients' views of the work of the nurses. The functions of the visitors twenty five years ago are described in the Report for 1906-7. 'The Committee consists of twelve ladies, besides the officers. Each lady undertakes to visit the patients on the books for one month in each year, and by this means she is given a personal interest in the work of the nurse, and also has cases of poverty and distress brought to her notice.' At that time much more supplementary relief was necessary than is necessary now, and in some cases grants for supplementary relief were made from the funds of the Association. It has always been the custom for the monthly visitor to take some gift of food to the cases visited (and at one period she was provided by the then existing Invalid Kitchen with a certain number of beef tea tickets for distribution), but though this is still done, the gifts are now regarded as friendly presents rather than as a form of supplementary relief. Another change is that now only those cases are visited who, in the nurses' opinion, would appreciate it. Visiting has been specially appreciated by some of the chronic cases. The Association has recently resumed the practice, which had dropped for some time, of including midwifery and maternity cases in those visited.

#### TILL COLLECTING OF FUNDS

As was shown above, the Association has a large number of subscribers to its house-to-house collections. In 1934-5 there were thirty-three collectors—all of them were women and ten of them were also members of the Committee. Occasional meetings of collectors have been held.

#### THE PERSONNEL AND WORK OF THE OFFICERS AND COMMITTEE

The officers of the Association have been the President (since 1885), Honorary Secretary (with a Joint Secretary for a short period), and Honorary Treasurer. There have only been two Presidents since the founding of the Association—the original President served from 1885 till 1911, when the

present President took office. Both the Presidents have been doctors and they have acted as advisory officers to the Association, but have not attended committee meetings except on special occasions. Except for the President, the officers and committee members have all been women. The committee meets in a morning once a month, and, except for temporary purposes, there have never been sub-committees. The number of committee members, including the secretary and treasurer, has been about twelve to eighteen over the whole period. There have been no working-class members of the committee, but a few of the collectors are working-class.

A study of the committee minute-book shows the kind of questions that are most frequently dealt with in meetings. The fact that the nurses are working independent of any constant professional supervision (in contrast to the position when they are living in Homes under a superintendent) means that much more of the detailed administrative work falls on the committee and on the honorary secretary. Arrangements must frequently be made by the committee and secretary for the appointment of new nurses, or for substitute nurses during holidays and during emergencies of illness and accident. (Arrangements for substitute nurses have become much easier in recent years because they are now supplied to affiliated associations by the Oxfordshire Nursing Federation.) Arrangements must also be made about patients—the fixing of special fees or the remission of fees, and the provision of or arrangement for special help of various kinds, and besides these special matters the list of cases on the books is always gone through at committee meetings. The arrangements as to monthly visitors, collectors, and changes of committee members are also matters regularly occurring at meetings, and in recent years also the reports of the Association's representatives at meetings of the Oxfordshire Federation.

In between the committee meetings the honorary secretary is available for consultation with the nurses and to deal with any questions that arise. For a long period the secretary saw each nurse regularly once a week. Over most of the period since the founding of the Association there have been

only three individuals acting as honorary secretary—one from 1875 to 1891, one from 1898 to 1924 (with a joint secretary for a few years of the period), and the present secretary since that date

Public annual meetings have been held since 1907, though they were not held quite every year in the pre-War period. They have been held in various places including the Town Hall, the Guardians' Offices, and the Public Health Clinic. The chair has usually been taken either by the Mayor or by the President of the Association, and sometimes there have been special speakers. The meetings have not usually been well attended, but have always been well reported in the local press, and those taking part in the meeting have often used the opportunity to discuss general questions affecting the health of the town as well as the work of the Association. The practice is to advertise the meeting in the press but not to notify subscribers directly. (However all subscribers of 1s and upwards are given copies of the printed annual report.) As in Birmingham, there never seem to have been nominations of committee members made at annual meetings from the body of the meetings, and new members have really been appointed by a process of co-optation.

## CHAPTER XV

### DISTRICT NURSING IN A RURAL AREA OF OXFORDSHIRE

#### THE AREA COVERED

The area covered by the three associations described in this chapter is a rural area of North Oxfordshire. The areas of the associations stretch in a continuous belt, in the order described, from about fourteen miles south-west of Banbury to the borders of the town.

The first association described combined, until very recently, nursing on the Cottage Benefit System with district nursing, the other two associations are typical village district nursing associations. However there is one feature of the work of rural associations of which they do not provide examples: in many counties district nurses act as part-time health visitors and school nurses in rural areas, but in Oxfordshire the County Council employs its own staff for this work (with a few minor exceptions).

#### THE NORTH OXON BENEFIT NURSING ASSOCIATION (HEYTHROP BRANCH)

##### GENERAL ORGANIZATION

The North Oxon Benefit Nursing Association (Heythrop Branch), to which I shall refer as the 'Heythrop Association,' covers a wide area. Its largest centre of population is Hook Norton, which lies about 8 miles south-west of Banbury. As it combines Cottage Benefit Nursing with district nursing its area is rather difficult to define. The Queen's Institute

Survey gives its area as including the following parishes for purposes of district nursing

	Population
Hook Norton	1,153
Great Rollright	289
Swerford	194
Heythrop	329
Enstone	888
Great and Little Tew	548
<i>Total Population</i>	<i>3,401</i>

To cover this area two district nurses are employed, one living at Hook Norton and one at Enstone. Besides these nurses, two nurses are employed for resident work in a rather wider area. The whole area covered by the Association includes eleven villages, those mentioned above and Ditchley, Spelsbury, Wigginton (also covered by the South Newington Association), and Cherrington, which is outside the county in Warwickshire.

The Association was started in 1892, and then covered a rather different area from the present one. In its first year of working three nurses were employed, attending 37 cases, and the income of the Association was £138. The number of the staff increased to a maximum of eight in 1911.

Until 1932 the Association did no district nursing in the ordinary sense. That is to say, its nurses were not visiting nurses attending all cases who might need them from day to day, but resident nurses living in the homes of their patients during the period in which their services were required. They worked on the Cottage Benefit Nursing System and, as this system has played an important part in the history of domiciliary nursing in rural areas, something will be said here of its history and principles.

#### THE COTTAGE BENEFIT NURSING SYSTEM

The Cottage Benefit Nursing Association was founded in 1883 by Miss Bertha Broadwood to promote rural nursing on what was called the 'Holt-Ockley' system. It had affiliated branches in many parts of the country, of which the Heythrop

Association was one (In 1897 there were nine other branches in Oxfordshire besides the Heythrop Branch) The idea of the system was to supply nurses who would live in at their patients' homes and do any necessary cooking and housework in addition to nursing The advantages of such a system were particularly great in areas where the population was very scattered, especially before the development of modern transport facilities The nurses were not usually hospital trained but were given a training in simple sick nursing and maternity nursing, and, after the passing of the Midwives Act, some of them qualified as midwives In 1909 the central Cottage Benefit Nursing Association had 137 affiliated branches, employing 500 nurses Since the War the system has become less prevalent, though the Central Association still exists and the system still covers considerable populations in five counties besides Oxfordshire—Leicestershire, Northumberland, Surrey, Warwickshire, and the East Riding of Yorkshire (In the East Riding it is very important, covering two-thirds of the population)

As a consequence of providing resident nurses the Heythrop Association from the first had a system of provident subscriptions and of fees charged The rates of both were graded according to the economic position of the member, and higher fees were charged to non-members This system survives, and there are now six grades of membership subscriptions and corresponding grades of fees charged for the services of both resident and district nurses The grades range from those in receipt of less than the agricultural minimum wage to the professional classes, and the annual membership subscriptions range from 2s to 10s Weekly fees for resident nursing range from 3s 6d to 17s 6d, fees per visit for district nursing from 3d to 1s 4d, and non-resident midwifery fees from £1 1s. to £2 2s Double fees are charged to non-subscribers A subscription covers all the dependent members of a family

In Hook Norton there are (1935) about 140 subscribers Collections are made quarterly, but each individual is collected from only once every six months

In 1934-5 the two resident nurses attended 25 cases, of which 16 were general cases and 9 maternity cases Maternity cases have always been a considerable propor-

tion of the total cases attended by the Association For example, in 1907-8 out of 107 cases attended, 61 were confinement cases There is in the Annual Report for that year an eloquent defence of the value of resident nurses for such cases ' There has been a great attempt lately to spread the idea that District Nurses are superior to Cottage Resident ones, because they can visit so many more cases in a day, which is true , but of what use is it to a labourer's wife in her Confinement to have a Nurse come in for half-an-hour or so and then go away ? There is the household work to do, the children to be seen to, the meals cooked, and unless the services of a neighbour can be secured, which would be a double cost, there is no alternative but for the patient to get up, at the serious risk of injuring herself permanently, and seeing to these matters herself This was the old bad way, and this would happen again if District Nurses superseded the cottage resident ones in country districts '

One of the difficulties of the Cottage Benefit System is to fit in the demand for and supply of the nurses' services at different periods At present the resident nurses tend to have time on their hands in the summer (when, however, they can now be employed in relief district nursing, either in the Heythrop area or in neighbouring areas) and tend to be over-booked in the winter In the early days of the Association there was constant borrowing of nurses from other Cottage Benefit Associations and also constant lending to them In recent years, though nurses are still borrowed and lent, the area of choice has been limited because of the closing down of several neighbouring Cottage Benefit Associations and the shortage of resident cottage nurses This was one reason for the decision of the Association in 1931 to start the employment of district nurses as well as resident nurses The two resident nurses now employed are available, especially for those parts of the area out of reach of the district nurses, as well as for other cases most urgently needing a nurse to live in, and there is still a good deal of demand for them

#### THE DISTRICT NURSING WORK OF THE ASSOCIATION

The two district nurses now employed are both qualified midwives. (So also is one of the resident nurses.) In 1910,

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when the Midwives Act came fully into force, three of the nurses on the staff of the Association were qualified midwives, but since the War there had been no midwives on the staff until about 1930. The organization of a midwifery service was much favoured by the doctors of the neighbourhood, who often had to go long distances to a case. Of the 98 district nursing cases attended in 1934-5, 29 were midwifery cases, 40 medical, and 29 surgical. A total of 2,036 visits were paid.

FINANCE

The following Table shows the sources of the £387 of ordinary income received by the Association in the year 1934-5. Nearly half the income came from the subscriptions of members and the fees paid both by them and by

NORTH OXON BENEFIT NURSING ASSOCIATION (HEYTHROP BRANCH)  
SOURCES OF INCOME FOR THE YEAR 1934-5

	£	Proportion of Ordinary Income %
Total Ordinary Income .	387	100
Donations . . . . .	82	21
Special Efforts . . . . .	34	9
Grants from Local Charities . . . . .	3	1
<i>Total Charitable Gifts . . . . .</i>	<i>118</i>	<i>30</i>
<i>Interest . . . . .</i>	<i>..</i>	<i>..</i>
Subscriptions and Fees from Villages.	180	47
Loans of Nurses . . . . .	46	12
Public Midwifery Grant	35	9
Public Assistance Committee Grant	7	2
<i>Total Payments for Services Rendered</i>	<i>268</i>	<i>69</i>



non-members in the area covered (The subscriptions of 'honorary subscribers' are also included but there were very few of them) Membership subscriptions and fees have always been an important proportion of the income of the Association, and in this respect the history of its finance is very different from that of associations which have always worked on the district nursing system, and whose income from fees and provident subscriptions is a more recent development (In 1892-3, the first year of working of the Heythrop Association, neither the Birmingham Society nor the Banbury Association had any income in contributions from patients) Besides payments for the nurses' services within the area, £46 was received in payments for their services in other areas

The Association received two forms of public grant Of these the more important was the grant of £35 in aid of midwifery, received from the Oxfordshire County Council through the Oxfordshire Nursing Federation (to which the Association affiliated in 1924) As was explained in reference to Banbury, this grant (of which the total amount in 1934-5 was £1,517) is allocated by the Federation to the district associations after considering all the circumstances of the case The grant to the Heythrop Association in 1934-5 worked out at about £1 4s per district midwifery and maternity case, and at about 18s 6d per case if the nine resident maternity cases are included

The grant from the Public Assistance Committee of the Oxfordshire County Council is also distributed through the Oxfordshire Nursing Federation The total grant at present is £211 per annum and this is distributed among the district associations at a uniform sum per nurse employed In 1934-5 the sum worked out at £3 9s 2d per nurse, and the year previously at £3 8s The Heythrop Association gets the grant only for its two district nurses It has received a public assistance grant since the year 1927-8 Old age pensioners are included in the lowest subscription class of the membership scheme and usually like to belong to it they are then excused any payments for visits Even persons in receipt of poor relief often belong to it The Public Assistance Committee grant is not an appreciable proportion of total

income. The two public grants together accounted for 11 per cent of income in 1934-5.

The total proportion of income in that year received in payments for services rendered was 69 per cent. There was no record of any receipts from interest nor of any capital investments.

Donations included sums from two Oxford colleges which own land in the area, also one large donation of £50. Special efforts included four rummage sales and two whist drives. The total receipts from charitable gifts were 30 per cent of total income. The outstanding feature of the finance of the Heythrop Association is the large proportion received in fees and provident subscriptions.

#### THE VOLUNTARY PERSONNEL AND ITS WORK

The Committee of the Association consists of eleven members, one in each of the villages covered. All the members are women and none of them are of the working class. The committee meets twice a year. The committee member in each village acts as the person generally responsible there and collects local subscriptions and fees. The member at Enstone, where one of the district nurses lives, has a good deal of responsibility for the work of the nurse there. The responsibility for the general arrangement of the work of the other district nurse and of the two resident nurses falls on the Honorary Secretary, who lives at Hook Norton. The arrangements for the resident nurses involve a great deal of work.

No annual meeting of subscribers is held. An Annual Report is published and given to the subscribers of larger amounts and to any others who ask for it.

The system of having a committee member in each village covered has existed throughout the history of the Association. The first officers of the Association gave their services for long periods, both the Secretary and the Treasurer acting for between twenty and thirty years.

#### CHANGES SINCE MARCH 1935

Since the 31st March 1935, the end of the period covered by this survey, there has been an important change in the

work of the Association. The Association has reluctantly abandoned the employment of resident nurses, at any rate for the present.

Several reasons have led to this decision. It is very difficult now to get nurses willing to take up resident work, including the housework involved in their duties under the Cottage Benefit system. They prefer to do work where their specialized training is fully used. Another difficulty is that there are now only two other Cottage Benefit associations within reasonable reach, from which nurses can be borrowed. It is proposed to supply the district nurse at Enstone with a car so that she can reach villages which have formerly been out of her reach.

#### THE SOUTH NEWINGTON DISTRICT NURSING ASSOCIATION

The full name of this Association is the South Newington, Wigginton, Barford St Michael, Barford St John and Milcombe District Nursing Association, and it covers the five villages included in the title, with a total population of about 950. These villages all lie between about four and six miles from Banbury, in a south-westerly direction.

The Association was founded in 1929, largely as the result of the efforts of a well-to-do resident, herself an ex-nurse. One village nurse-midwife is employed, who attended a total of 123 cases in 1934-5 and paid 2,571 visits. Of the cases attended 2 were midwifery, 3 maternity, 52 medical, and 66 surgical. The Association has been affiliated to the Oxfordshire Nursing Federation since its formation, and it receives visits from the County Superintendent three or four times a year. The Oxfordshire Federation owns the house in which the nurse lives and the South Newington Association owns a car which is used by her. Both the house and the car were gifts.

#### FINANCE

The following Table shows the sources of the £283 of ordinary income received by the Association in 1934-5

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The most striking feature in it is the large proportion of income received from special efforts. Of the total of £140 produced by these £131 came from a garden fête. As a result of this exceptional income there was an excess of £77 in the amount of total income over total expenditure. Of the £51 income from subscriptions and donations £43 was in annual subscriptions from thirty-four subscribers, including four Oxford colleges owning land in the area.

SOUTH NEWINGTON DISTRICT NURSING ASSOCIATION  
SOURCES OF INCOME FOR THE YEAR 1934-5

	£	Proportion of Ordinary Income. %
Total Ordinary Income	283	100
General Subscriptions and Donations	51	18
Special Efforts	140	49
Grants from Local Charities	3	1
<i>Total Charitable Gifts</i>	<i>194</i>	<i>69</i>
<i>Interest</i>	<i>..</i>	<i>..</i>
Provident Subscriptions	44	16
Non-members' Fees and Payments for Special Services	5	2
Midwifery and Maternity Nursing Fees	6	2
Public Midwifery Grant	30	11
Public Assistance Committee Grant	3	1
<i>Total Payments for Services Rendered</i>	<i>89</i>	<i>31</i>

With regard to interest the Table is misleading, as, though there was no interest included in ordinary income, there was

£2 10s interest on the Association's deposit account. The total amount in this account at the end of the year was £163.

The Association received £44 in subscriptions from members of the provident scheme. The ordinary members of this scheme pay 6d a month. This amount includes the children of members up to the age of sixteen, but wage-earning children over sixteen are not included and can become members at 4d a month. These membership subscriptions entitle members to free general nursing and to midwifery at a fee of £1 5s, and maternity nursing at a fee of 15s (these fees are sometimes modified). Non-members pay double fees for midwifery and maternity nursing and are charged according to their means for general nursing. There are no special rules for old age pensioners or persons in receipt of public assistance. All those subscribing 10s or more annually are entitled to five visits without charge, in any one year and are charged 6d a visit for visits in excess of five. This rule is intended to apply to subscribers who are better off than the ordinary members and who often avail themselves of the services of the nurse. In March 1935 there were 163 ordinary members—52 in South Newington, 44 in the two Barfords, 34 in Milcombe, and 33 in Wigginton. The collections are usually made monthly. The fact that collections are also made in the area for the contributory scheme of the Banbury Hospital has not affected the Association's scheme unfavourably.

The grant from the Oxfordshire County Council for midwifery was 11 per cent of total income and five times the amount received in fees for midwifery and maternity nursing. As there were five midwifery and maternity nursing cases the grant worked out at £6 per case. Before the starting of the Association there was no qualified midwife in the area.

#### THE VOLUNTARY PERSONNEL

The Committee consists of twenty members, including the four officers. An effort is made to have two or three committee members from each village, and the President for the year is chosen from each village in rotation. Three members of the committee are men. Some of the collectors

are of the working class but none of the committee members. An annual report is published and an annual meeting of members and subscribers is held

### THE BLOXHAM DISTRICT NURSING ASSOCIATION

This Association covers the village of Bloxham, which lies between three and four miles south-west of Banbury and has a population of about 1,200. The earliest date at which a district nurse lived in Bloxham was about 1908. There had been a previous unsuccessful experiment with a nurse on the Cottage Benefit system. In 1931 the Association was restarted and reaffiliated with the Oxfordshire Nursing Federation, after having been in abeyance for a year.

The Association employs one village nurse-midwife, who, in 1934-5, attended a total of 74 cases and paid 1,847 visits. Of the cases 8 were midwifery, 1 maternity, 29 medical, and 36 surgical.

The Association is financed by a provident membership scheme, fees for midwifery and maternity nursing, some general subscriptions, an annual flag day, jumble sale and garden sale, grants from parish charities, and Public Assistance and midwifery grants from the Oxfordshire County Council.

### THE VOLUNTARY PERSONNEL AND ITS WORK

The Committee of the Association consists of ten members including the officers. All the members of the Committee are women and most of them are working-class members of the provident scheme. The Committee meets once a month and at the end of the meeting the nurse attends to answer questions. In between the Committee meetings the nurse sees the Honorary Secretary every week. The Honorary Treasurer, who is a man, is not a member of the Committee. An annual meeting of members and subscribers is held, only poorly attended. The Annual Report is presented at this meeting and posted up for a few days for inspection, but is not published.

The collecting of provident subscriptions is done once a month by the Committee members. As in the South Newington area, the collections which are made for the contributory scheme of the district hospital do not prejudice the Association's scheme.

## CHAPTER XVI

### THE DEPARTMENTS OF WORK OF DISTRICT NURSING ASSOCIATIONS

#### GENERAL ORGANIZATION AND STATISTICS

THE last three chapters have given detailed descriptions of the organization of district nursing in three types of area. The remainder of this survey of district nursing will describe and discuss various aspects of organization over the country as a whole

Outside the Metropolis district nursing is organized by district nursing associations covering well-defined local areas—cities, districts of cities, towns, villages or groups of villages. (In a few areas district nurses for general work are provided by the local voluntary hospital.) There is very little overlapping between local associations, even when they are working entirely independently. All those associations employing Queen's Nurses are affiliated to the Queen's Institute either directly or through county nursing associations, and the work of their nurses is inspected regularly, either directly by the Institute or by the County Superintendent of the county nursing association. At the end of 1934 there were 1,006 associations employing Queen's Nurses. There were also about 2,539 associations affiliated to the 45 county associations affiliated to the Institute, but not employing Queen's Nurses.

Of the 62 administrative counties 60 are covered by 55 county nursing associations. (Some county nursing associations cover more than one administrative county.) Ten of these associations work independently of the Institute, and the rest are affiliated to it. In most rural areas and small towns the local associations are affiliated to the county association. In many county boroughs the district associations are not affiliated to the county association. (Lancashire



is an important exception it is a recently formed county association and has affiliated to it nearly all the district associations in its area, though the large associations have their own Superintendents and do not come under the inspection of the County Superintendent) The number of district associations affiliated to some of the county associations is more than 100, e.g. in Cheshire, Cornwall, Kent, Norfolk. The county associations provide a variety of services for their affiliated members, including the training of nurses, the recommendation of candidates for appointments, the supplying of nurses for duty during holidays and emergencies, the inspection and advice of the County Superintendent, the administration of grants from the County Council, the administration of pensions schemes. In addition, they have constantly borne in mind the needs of their areas as a whole, and have endeavoured to cover the whole county with a district nursing service and to get district associations started in districts where none exist.

The position in the Metropolis is more complicated. Dr Hogarth's Survey of the County of London in 1931 showed that there were in the County at that time 22 district nursing associations affiliated to the Queen's Institute, employing between them 213 nurses, and 10 associations, not affiliated, employing between them 72 nurses. Some of these latter associations were attached to religious denominations, and there were in addition a few nurses working under Church of England parishes. There were also 92 Ranyard Nurses.

The Ranyard Nurses are the only important case in the country in which an association engaged in the work of district nursing is organized on a definitely religious basis. They are also the only important case of a system of training for district nurses other than the system of training for Queen's Nurses and village nurse-midwives by associations affiliated to the Queen's Institute. The Ranyard Nurses are the Nursing Branch of the London Biblewomen and Nurses Mission. The Nursing Branch was founded by Mrs. Ranyard in 1865, and it and the East London Nursing Society, which started work in the same year, were the first bodies to organize district nursing in the Metropolis on any considerable scale. The Nursing Branch of the Mission works quite independently

of the Biblewomen's branch The Mission appoints only State Registered Nurses to whom it gives a district training of six months After training, the nurses are allocated to one of the forty or so districts in which the Mission works These

NUMBER OF COUNTY AND DISTRICT NURSING ASSOCIATIONS AND  
NUMBER OF NURSES EMPLOYED AT THE END OF 1934

	England	Wales	Total
<b>NUMBER OF ASSOCIATIONS</b>			
<i>County Associations</i>			
Affiliated to the Queen's Institute	35	10	45
Not affiliated	7	3	10
<i>Total</i>	42	13	55
(covering 60 out of 62 Administrative Counties)			
<i>District Associations affiliated directly or indirectly to the Queen's Institute</i>			
Associations affiliated to the 45 County Associations affiliated to the Queen's Institute			
(a) Employing Queen's Nurses	710	c 89	c 799
(b) Not employing Queen's Nurses	2311	c 228	c 2539
Associations affiliated to the Queen's Institute and employing Queen's Nurses, but not attached to affiliated County Associations	200	c 7	c 207
<i>Total</i>	3221	c 324	c 3545
<b>NUMBER OF NURSES EMPLOYED</b>			
<i>Total Nurses employed by All Associations</i>	6727	558	7285
<i>Nurses employed by Associations affiliated directly or indirectly to the Queen's Institute</i>			
Queen's Nurses	2361	152	2513
Village Nurse Midwives			2823
Other Nurses, including candidates in training			821
<i>Total</i>	5709	448	6157

districts usually follow the parish boundaries, but no distinction of creed is made among those nursed Instead of living together in Homes (as is the case with the nurses employed by most large district nursing associations), the Ranyard Nurses live in lodgings in the district in which they work, and are kept in touch with headquarters by a system of visiting

superintending sisters ' The ideal of the Ranyard Mission is thorough efficiency in nursing, combined with a deep sense of religious vocation '

## 1 GENERAL NURSING

The early district nursing associations were started to provide the services of trained nurses to do visiting nursing in the homes of the poor. Many associations have now included also other departments of work, but general visiting nursing remains an important part of the work of all associations, and is the only department of work undertaken by them all.

There are no collected figures available of the total number of general nursing cases attended and visits paid over the whole country, but the following sample figures for certain associations will give some idea of the amount of the general nursing work in 1934

	Cases,	Visits
<i>Counties</i>		
Oxfordshire County Nursing Federation, including 53 D N A s	3,845	71,742 (excluding casual visits)
Suffolk (East and West) Nursing Association, including 115 D N A s	12,906	268,085
Glamorgan County Nursing Association, including 55 D N A s	6,932	177,027
<i>County Boroughs</i>		
Birmingham D N A	10,330	345,451
Liverpool Queen Victoria D N A	7,139	189,694
<i>London</i>		
Metropolitan D N A	3,162	81,996
Ranyard Nurses	10,412	318,207

The following list of a typical day's cases attended by a town nurse is abbreviated from an article by Dr. Arthur Shadwell (' The Times,' 27th September 1926).

- (1) Pneumonia—man
- (2) Acute rheumatism—woman.

- (3) Bronchitis—baby
- (4) Cardiac case—woman
- (5) Empyema—young man    Surgical dressing.
- (6) Ulcer    Surgical dressing
- (7) Rheumatoid arthritis—woman
- (8) Called in by mother to ask about baby not doing well
- (9) Cancer—woman
- (10) Second visit to No 3
- (11) Second visit to No 2
- (12) Second visit to No 1

This list gives a good idea of the variety of general nursing cases. In her survey of London in 1931, Dr Hogarth says of the general nursing cases 'The majority—about 70 per cent—are medical cases, the remaining 30 per cent. requiring surgical dressings and treatment. Calculating an acute illness as one requiring nursing services for twenty-one days or less, and taking cases nursed by two large associations, roughly between 70 per cent and 80 per cent. are suffering from some form of acute illness.'

As a general rule district nurses attend general sick nursing cases only when they are under medical supervision, and the nursing is done under that supervision, though often the communication between doctor and nurse is in writing only. The rule for a Queen's Nurse is that 'She may attend a patient on application or in emergency, but must not continue to visit without informing a medical man and receiving his instructions, if any. Should the nurse advise that a patient should have a doctor and the advice be not accepted, she may not attend, except in case of fresh emergency, and must report the matter to her Hon. Secretary.'

Cases are referred to the association or the nurse by doctors, hospitals, patients' families or friends, and from various other sources. Besides the cases referred, some are discovered by the nurse in the course of her rounds. The Queen's Institute lays it down with regard to those associations affiliated to it that 'The primary duty of the nurses shall be to attend in their own homes, without distinction of creed, those who are unable to employ a private nurse, free nursing being given in cases of necessity.' District nursing associations have always considered themselves available to

help all those needing their services. Where membership schemes exist the services of the nurse are not confined to members, and even those few associations (of which the Ranyard Nurses are the most important) which are on a definitely religious basis do not make any discrimination of creed with regard to the cases nursed.

#### THE DEGREE OF ADEQUACY OF THE GENERAL NURSING SERVICE

The purpose of the statistical 'Survey of District Nursing in England and Wales,' published by the Queen's Institute in 1935, and already referred to, was to give as accurate an estimate as possible of the degree of adequacy of the general nursing service throughout the country. The figures cover the work of all associations providing domiciliary nursing, whether affiliated to the Institute or not. They refer to the end of 1934, and since that date there has been an improvement in the position.

There are two aspects of the problem of adequacy dealt with in the Survey. The first is what proportions of the population in different areas have *any* district nursing service available. The second is to what extent, when a service is available, the number of nurses employed is sufficient.

(1) With regard to the first aspect of the problem, the general position was that 95 per cent. of the population of England and Wales was within areas served by district nursing associations. The total 'population un-nursed' was 1,657,000.

As might be expected, this un-nursed population was unevenly distributed in different parts of the country and different types of area. There was no un-nursed population in the County of London, nor in any county borough except parts of Merthyr Tydfil and Stoke-on-Trent. In addition to these large urban areas the following Administrative Counties were completely covered with some nursing service—Anglesey, Hertfordshire, East Suffolk, East and West Sussex, Isle of Wight, and the East Riding of Yorkshire. (The last of these was covered to the extent of only a third by a *district* nursing service, the remainder being covered by a Cottage Benefit Nursing Service of the kind described in Chapter XV.)

At the other end of the scale the following Administrative Counties had 20 per cent or more of their population un-nursed Monmouthshire, 32 per cent, Holland (Lincolnshire), 23 per cent, Glamorganshire, 22 per cent, Norfolk, 22 per cent, and Lindsey (Lincolnshire), 20 per cent. The actual number un-nursed exceeded 100,000 in the following counties: West Riding of Yorkshire, 201,090, Glamorganshire (including Merthyr Tydfil), 186,000, Kent, 127,000, Staffordshire (including Stoke-on-Trent), 110,000, Monmouthshire, 108,000.

It is not possible with the information at my disposal to suggest adequate explanations of these local variations, but it is obvious that sparsely populated rural areas are more likely to be out of reach of any nursing service than large towns, and also that one of the 'depressed areas' has suffered in this respect.

The absence of a district nursing service in a rural area usually implied also the absence of any subsidized midwifery service up to the passing of the Midwives Act, 1936. This subject is dealt with below, but it may be noted here that the wish to provide qualified midwives for the inhabitants of rural areas has been one of the most important motives leading to the increase in the number of village nursing associations. Before the Local Government Act, 1929, the Annual Report of the Ministry of Health used to give information as to the number of new district nursing associations formed, and as to the proportion of the rural population provided with the services of a trained midwife. These figures show that in England (not including Wales), in the eight years 1921-8, about 600 additional nursing associations were formed, and that the proportion of the rural population of England for whom trained midwives were available increased from 68 per cent to 82 per cent.

(2) The second aspect of adequacy dealt with in the Survey is the sufficiency or insufficiency for the needs of their areas of the number of nurses employed by the various associations.

The estimates of local adequacy made in the Survey are based on the size of the population to be served and the character of the district. Where the nurses do general nursing only, it is estimated that one nurse is required per 7,000-9,000 population, where midwifery is also undertaken one nurse

per 5,000–6,000 population; and where public health duties in addition to general nursing and midwifery are undertaken one nurse per 3,000 population

The Survey showed a total of 7,170 nurses employed in England and Wales—an average of one nurse per 5,329 population—and estimated an additional 1,625 nurses as required to 'complete the service' (These figures included the nurses required for areas completely un-nursed) Thus, on this basis of estimating adequacy, out of roughly 8,800 nurses required, about 80 per cent were already employed an increase of between a fifth and a quarter of the number already employed would solve the problem of quantitative adequacy, as far as general nursing is concerned

The figures for the main classes of area are as follows —

	Number of Nurses		Percentage Increase Required
	Employed	Required	
<i>England</i>			<i>n/d</i>
County of London	335	211	63
County Boroughs	1148	548	48
Administrative Counties	5134	739	14
<i>Total</i>	<i>6617</i>	<i>1498</i>	<i>23</i>
<i>Wales and Monmouth</i>			
County Boroughs	48	21	44
Administrative Counties	505	106	21
<i>Total</i>	<i>553</i>	<i>127</i>	<i>23</i>
<i>Total England and Wales</i>	<i>7170</i>	<i>1625</i>	<i>23</i>

(The figure for the total number of nurses employed in England and Wales differs from the total of 7,285 given in the Table earlier in this chapter because of the subtraction of 78 nurses employed in London in school clinic work and 37 nurses employed in London and three County Boroughs in midwifery and maternity nursing)

Of the 83 County Boroughs in England and Wales 21 had an entirely adequate service This list included the following with populations of more than 100,000 — Brighton, Derby, Huddersfield, Leicester, St Helens At the other end of the scale there were 21 County

Boroughs which needed to double, or more than double, the number of nurses employed. This list included the following, with populations of more than 100,000—Birkenhead, Blackpool, Croydon, Gateshead, Hull, Middlesbrough, Nottingham, Oldham, Sheffield, Southend-on-Sea, South Shields, Stoke-on-Trent.

There were not such large variations among the Administrative Counties. Only one County in England and two in Wales had completely adequate services—Cambridgeshire, Anglesey, and Radnorshire. (In the case of Anglesey the service was adequate both quantitatively and geographically. In the case of the other two counties there were areas un-nursed, but the Survey considered that these areas could be covered by existing associations without the employment of extra nurses.) Several other counties had nearly adequate services. At the other end of the scale there were no counties needing to double the number of nurses employed, but the following needed to increase it by 50 per cent or more in England—Holland (Lincolnshire), Middlesex, Soke of Peterborough, in Wales—Glamorgan and Monmouthshire.

In the County of London, where the service as a whole needed increasing by more than 50 per cent, the only Boroughs adequately served were the City of London and Finsbury. At the other end of the scale the service needed increasing fourfold in Battersea and more than threefold in Islington—in both these cases the average population per nurse was 31,000.

The most striking conclusion from this survey of the degree of adequacy of the number of nurses in different areas is that on the whole the service was considerably more adequate in the small units of population than in the large units. The Administrative Counties as a whole were better served than the County Boroughs as a whole, and the County Boroughs were better served than the Metropolis.

This conclusion is also true as between the County Boroughs—on the whole the smaller County Boroughs were served more adequately than the larger ones. Of the 21 County Boroughs mentioned above, which had an entirely adequate service, only five had a population of more than 100,000, and only one—Leicester—had a population of



more than 200,000. Of the 21 County Boroughs at the other end of the scale, those which needed to double, or more than double, the number of nurses employed, twelve had a population of more than 100,000, and four—Croydon, Hull, Nottingham, and Sheffield—had a population of more than 200,000. Of the other ten County Boroughs with over 200,000 population, six needed to increase the number by more than 50 per cent.

The other side of this picture is the success with which the service has been organized in several of the rural counties. This is perhaps most remarkable in the case of rural Wales, where some of the conditions of organization and work must be very difficult—Anglesey and Radnorshire had completely adequate services, Caernarvonshire, Merionethshire, and Montgomeryshire each needed only one additional nurse to complete their service.

It is very difficult to account for these general facts, and the following are only tentative suggestions of possible influencing factors.

(1) In a sparsely populated rural area there are only two alternatives, either to have no service at all or to have an adequate one—because there is not likely to be work for more than one nurse. (A very large majority of village Associations employ only one nurse.) The public is more likely to be impressed with the need for some service in an area where none exists than with the need, in a large town, to increase the adequacy of an existing service.

(2) Provident schemes have, in the past, been more general in rural areas than in towns.

(3) As will be described below, the district nursing service in rural areas has been aided largely by the public grants for midwifery, and also in some areas by grants for the public health work of nurses as health visitors and school nurses. In the large towns very few associations undertake midwifery or this type of public health work, so that this help has not been available.

(4) It is possible that in large towns the services of both public and voluntary hospitals (with regard to both in-patients and out-patients) are substitutes for the services of the district nurse in some types of case in a way that is im-

practicable in inaccessible rural areas. Also in towns the appeal of nursing associations for funds tends to be overshadowed by the greater publicity of hospital appeals.

(5) The associations in the large towns have used their resources to employ better qualified nurses at larger salaries than the Associations in rural areas. To this statement there are exceptions on both sides, but it is broadly true. In three-quarters of the County Boroughs the Association (or, where there is more than one Association, the main Association) employs Queen's Nurses. On the other hand, in the areas of the 35 County Associations affiliated to the Queen's Institute in England (not including Wales) only 1,034 Queen's Nurses were employed at the end of 1934 as against 2,622 other nurses (some of them State Registered Nurses), and in each of seven counties less than ten Queen's Nurses were employed. The Survey estimated that the cost (including other items of cost besides salaries) of a Queen's Nurse working by herself was £231 per annum over the average of the whole country, the cost of a Queen's Nurse in a Home under a Superintendent £207, and the cost of a non-Queen's nurse £184 10s. (In addition there is about £11 10s per nurse in costs of administration to the County Association in cases of nurses supervised by them.) So that Associations employing non-Queen's nurses are spending something between £22 and £46 less per nurse than those employing Queen's Nurses.

On the question of qualitative adequacy the Survey does not touch, and on this question it is obviously very difficult for any one outside the nursing profession to have a reasoned opinion. But it seems to me that if the standard of training asked for from a Queen's Nurse is a reasonable standard to expect from a district nurse in a town, then the standard of training of a village nurse midwife, in so far as general nursing is concerned, is inadequate. The lengths and conditions of training were given above on page 202, and it will be noted how wide is the difference between them. *A priori* one would expect the village nurse who must combine general nursing with midwifery—often also with public health work, must work without the constant supervision and advice possible in the Homes of cities, and is often without easy access to either doctor or hospital for her cases, to need a better train-

ing than the city nurse who need not take so much undivided responsibility. But, in general, she is much less well trained and less well paid. The difficulty of improving the standard of training and pay for rural nurses lies partly in lack of financial resources. But it lies also in the variety of duties of the country nurse and the time necessarily spent by her in travelling, which combine to make it impossible for her to use any specialized part of her training as intensively as does a city nurse. This problem is, of course, not peculiar to district nursing, and occurs in many cases of professional services in rural areas. (It may be noted that County Nursing Associations affiliated to the Queen's Institute try to ensure that in their areas 'village nurse-midwives' are employed only in districts where the population is 3,000 or less.)

It is clear, then, that, in a comparison of district nursing in large and small units of population, the following three facts are true as rough generalizations. (a) There are hardly any completely unserved areas in the large units. (b) The large units have a smaller number of nurses in relation to their populations. (c) The average standard of training of the nurses employed in the large units is considerably higher than that of those employed in the small units.

#### RELATIONS WITH PUBLIC AUTHORITIES

Until 1937 neither the Central Government nor the Local Authority had by law any *general* power either to organize or to make grants towards domiciliary nursing. Grants can be made for midwifery and maternity nursing and for public health work—these grants are dealt with in later sections of this chapter.

With regard to general nursing there are two types of grant legally possible in all classes of area and actually made in many cases—grants from Public Assistance Committees, and grants for the nursing of notifiable diseases and cases under the Maternity and Child Welfare Act.

It is also possible for a Borough to make a grant to a district nursing association in return for services rendered to its servants. This is done in Birmingham, as was described on page 225, but this is, to the best of my knowledge, the only instance of such a grant.

There is a fourth type of grant possible not in all parts of the country but only in certain depressed areas. This type of grant has been made in all three 'Special Areas' as a result of the action of the Commissioner appointed under the Special Areas (Development and Improvement) Act, 1934

*Grants from Public Assistance Committees*—Under the Poor Law Act, 1930 (Section 67c), 'The council of any county or county borough may, with the consent of the Minister, contribute by way of an annual subscription towards the support and maintenance of any association for providing nurses. Provided that nothing in this section shall authorize any subscription to any institution unless the Minister is satisfied that the persons receiving relief from the council have, or could have, assistance therein in case of necessity' This section was a repetition of the substance of a section in the Poor Law Act of 1879 which gave Boards of Guardians similar powers

An order issued by the Local Government Board in 1892 empowered the Guardians to themselves appoint district nurses. The Report of the Poor Law Commission in 1909 states that, 'This power has not been largely used. As a matter of fact, only the Guardians of a few urban unions have appointed nurses'. I have no information about the present position in this respect, but, to the best of my knowledge, there are very few cases of nurses employed by Public Assistance Committees for the purpose of domiciliary nursing.

Some Poor Law Authorities have given grants to district nursing associations for several decades. It was noted above, for example, that the first grant from the Birmingham Board of Guardians was in 1892 and the first grant from the Banbury Board in 1899 (though in the latter case the grants since that date have not been continuous). In 1907, according to evidence supplied by the Queen's Institute to the Poor Law Commission, Boards of Guardians made grants to 242 Associations employing Queen's Nurses and to 144 Associations employing village nurses. In the first case, the total amount of the grants was about £3600—about 3½ per cent of the total cost of all Queen's Nurses employed at that date. In the second case, the total amount of grants was about £400—under

1 per cent of the total cost of all village nurses employed. The Report of the Commission comments that ' By means of these subscriptions, sometimes liberal but more frequently only nominal in amount, the Guardians in many unions now secure a certain amount of nursing for the outdoor sick '

It is difficult, with the information at my disposal, to form any accurate estimate of the relation between the amounts of the grants paid by Public Assistance Committees and the cost of the work done for them. But I should surmise that, with some exceptions, the grants do not cover the full cost of the nursing of patients in receipt of public assistance (including poor law medical relief). Still less do the grants amount to what the Public Assistance authorities would have to spend if they themselves organized a district nursing service. The view is often taken that the grants are intended to cover the free nursing of Old Age Pensioners and of other patients ' necessitous for nursing ' as well as of persons in receipt of public assistance, but this is not always the case. Some Public Assistance authorities have decreased their grants as the income of associations in their area from provident schemes has increased.

In many cases there are representatives on the committee of the county nursing association, or the district association in a County Borough, either from the Public Assistance Committee or from the County Council or County Borough Council as a whole.

(Section 67c of the Poor Law Act, 1930, has now been repealed by the Public Health Act, 1936, which, in Section 178, gives wider powers of assistance to nursing associations—see page 282 )

*Grants for the Nursing of Notifiable Diseases and Cases under the Maternity and Child Welfare Act*—Under the Public Health Acts and the Maternity and Child Welfare Act, Local Authorities can make payments to district nursing associations for the general nursing of certain special types of case.

The local authority has power under these Acts, and under regulations made under them, to provide or to aid domiciliary nursing of the following diseases. Most of these diseases,

except influenza, are notifiable either in all areas or by a special bye-law of the local authority

Influenza	Poliomyelitis
Influenzal pneumonia	Diphtheria
Acute primary pneumonia	Trench fever
Tuberculosis	Spotted fever
Measles	Dysentery
German measles	Enteric
Whooping cough	Malaria
Chicken pox	Erysipelas
Ringworm	Puerperal pyrexia
Ophthalmia neonatorum	Puerperal sepsis
Epidemic diarrhoea	Encephalitis lethargica

It has also power under the Maternity and Child Welfare Act, 1918, to provide or to aid domiciliary nursing of any condition of expectant or nursing mothers and of any condition of children under the age of five

These powers are not used at all by some authorities and when used they are often confined to only some of the diseases and types of case mentioned

With regard to certain of the cases mentioned above the Annual Report of the Ministry of Health gives the following figures for the end of 1934

‘ Number of nurses employed for the nursing in their homes of expectant mothers and of children under five years of age, for maternity nursing, and for the nursing of puerperal fever and puerperal pyrexia

(a) by Local Authorities.	49
(b) by voluntary associations .	2,732

Total number of cases attended by these nurses in 1934, 89,304 ’

It will be noted that these figures include maternity nursing I do not think that the figures imply that grants were given for all these cases

The Queen's Institute Annual Report gives figures for

the number of cases of certain diseases nursed by Queen's Nurses throughout the country in 1933, for which grants were paid by Local Authorities. There were 13,470 cases of pneumonia, 3,307 of measles, 4,764 of tuberculosis, 12,925 of diseases in children under five.

The powers of local authorities with regard to notifiable diseases and the nursing of cases under the Maternity and Child Welfare Act are exercised to very varying extents by different authorities, and where cases of any particular type are paid for they are paid for at very varying rates. If all local authorities used all their powers in these respects and gave adequate payments many district nursing associations would gain considerably financially.

*Grants in 'Special Areas'*—Under the Special Areas (Development and Improvement) Act, 1934, the Commissioner for Special Areas has given grants to aid district nursing in the Special Areas of Cumberland, Durham and Tyneside, and South Wales (also in Scotland, which is outside the scope of this survey). In his first Report (1935) the Commissioner says 'In time of prosperity it was not difficult for each local community to maintain the district nurse by means of small weekly contributions, but in the bad times of recent years many local associations have been kept alive only with great difficulty. In some districts the number of nurses is far below what is needed.'

In Cumberland it was not considered that additional nurses needed to be appointed but, in view of the great difficulty experienced by associations in the area in obtaining funds to enable them to maintain the efficiency of their services, grants were made where help was needed.

In Durham and Tyneside additional nurses were needed—about forty in County Durham. The Durham County Nursing Association was offered grants at the rate of £110 per nurse for additional nurses appointed by new or existing associations, and also £400 for distribution in aid of existing services in especially necessitous districts. Grants were also made to the Northumberland County Nursing Association and to the associations in the County Boroughs of Newcastle, Gateshead, South Shields, Sunderland, and West

Hartlepool By the end of 1935 twenty-one additional nurses had been appointed in Durham and Tyneside

In South Wales it was estimated that about seventy additional nurses were needed Grants were made to the Glamorganshire and Monmouthshire County Nursing Associations and up to the end of 1935 forty-seven additional nurses had been appointed

These grants have all been made through the National Council of Social Service The total amount of grants allocated up to the end of March 1936 was £22,000 It should be noted that many of the additional nurses appointed as a result of these grants are engaged in midwifery and maternity nursing as well as in general nursing, so that the grants have served to aid all these departments of work The grants were not intended to meet the full cost of the extensions of the service as the Commissioner says 'In every case it was deemed appropriate that some proportion of the cost should be raised locally'

*The Domiciliary Nursing Services Bill, 1934*—There has been a recent attempt to alter the law with regard to the powers of local authorities in relation to general district nursing This attempt was the Domiciliary Nursing Services Bill, introduced as a private member's bill in July 1934 It did not become law

The Bill provided that any local authority (including a county council) may 'provide domiciliary nursing services for the sick inhabitants of their district, and for that purpose do all or any of the following acts or things Appoint and pay nurses, Enter into any agreement with any person (including any voluntary association or institution) for provision of a supply of nurses, Make reasonable subscriptions or donations to a voluntary association or institution providing domiciliary nursing services' The expenditure on subscriptions and donations to a voluntary association shall not exceed two-thirds of the amount which a local authority is, for the time being, allowed to spend on subscriptions and donations to voluntary hospitals (This means at present that it may not exceed the proceeds of a 1d. rate)

It will be seen that if this Bill became law local authorities



would have general powers to organize or aid district nursing instead of powers confined to particular types of nursing

*The Public Health Act, 1936* —Although the Domiciliary Nursing Services Bill has not become law part of its objects have been attained by Section 178 of the Public Health Act, 1936, which came into force in October 1937

This Section states that 'A county council or local authority may contribute by way of an annual subscription towards the support and maintenance of any association for providing nurses' This is the first time that local authorities have been given power to contribute to the general nursing work of district nursing associations, except as part of their Public Assistance work It remains to be seen what use local authorities make of this new legal power

As a consequence of its inclusion of this Section the Act repeals Section 67c of the Poor Law Act, 1930, referred to on page 277 above In future, therefore, grants made by local authorities under the Public Health Act, 1936, will take the place of grants previously made first by Boards of Guardians and later by their successors, the Public Assistance Committees of counties and county boroughs

## 2 MIDWIFERY AND MATERNITY NURSING

There is no legal control of the work of general nurses, and the general nursing work of district nursing associations is carried on for the most part without help from public authorities With regard to midwifery the position is different in both respects

### THE LEGAL POSITION OF MIDWIVES

There was no legal control over the qualifications of midwives before the Midwives Act of 1902. That Act, which did not come into full operation until April 1910, provided that after that date 'no woman shall habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she be certified under this Act' Women might be certified if they had either passed one of a number of possible qualifying examinations,

or if they satisfied the Central Midwives Board that at the time of the passing of the Act they had been for at least one year in *bona fide* practice as midwives and were of good character (The proportion of midwives who are in this latter class has been steadily decreasing, and is now very small—on 31st March 1934 only 2·8 per cent. of all those on the Midwives' Roll) The Act constituted the council of every county and county borough the local supervising authority with regard to the midwives in its area (in some cases the supervision has been delegated to district councils) The Act also set up a Central Midwives Board for the purpose of regulating admission to the ranks of certified midwives, regulating the course of training and the conduct of examinations, and exercising general professional supervision over midwives throughout the country The amending Acts of 1918 and 1926 have made only minor alterations in the law relating to the legal conditions of midwifery practice With regard to maternity nursing (i.e. nursing under the supervision of a doctor), there has been no legal control until the Act of 1936

#### THE MIDWIFERY AND MATERNITY NURSING WORK OF DISTRICT NURSING ASSOCIATIONS

District nursing associations had already started to provide a midwifery service, especially in rural areas, before the passing of the Midwives Act That Act, however, gave a 'tremendous incentive for the extension of provision As was shown above in the account of the history of the Banbury Association, there were many places where it was necessary for a charitable association to employ (and often to arrange to have trained) a qualified midwife because otherwise no legally competent midwives would be available and all mothers would be obliged to employ doctors, whose fees they would be unable to pay The need for the provision of a subsidized midwifery service was, and still is, greater in rural areas and small towns than in large cities In large towns it is easier for an independent midwife to make a living, as there are more cases and less time need be spent in travelling Also large numbers of births take place in hospitals or at home under the supervision of the hospital staff and students.

Another factor is that in rural areas there is often no doctor in the near neighbourhood

Already in 1908 there were 774 midwives working in connection with associations affiliated to the Queen's Institute, and in that year they attended over 18,000 cases—about 70 per cent alone, and 30 per cent as maternity nurses under the supervision of doctors. In 1934 there were 4,087 midwives working in connection with the Institute and they attended about 68,500 cases. In counties where the associations are not affiliated to the Institute the number of midwives employed was about 800.

There are at present no administrative counties without some parts of their areas covered by midwives employed by district nursing associations. In 1934 out of the total population of 17·1 million in Administrative Counties nursed by associations affiliated to the County Associations, 11·9 million—70 per cent—were nursed by associations undertaking midwifery and maternity nursing as well as general nursing (there is no information on this matter with regard to the 3·4 million of population nursed by associations not affiliated). In some cases the associations concerned employ separate nurses for midwifery and maternity nursing (as is the case with the Banbury Association), but in most cases the same nurses are engaged in this nursing and in general nursing. This means that it is worth while employing a nurse-midwife in an area where the number of midwifery and maternity cases would be entirely insufficient to justify the employment of a midwife engaged only in maternity work. (The examples of the South Newington and Bloxham Associations, described above, illustrate this point. In the year 1934-5 one of these associations had 5 and the other 9 midwifery and maternity cases, but their nurses also attended 118 medical and surgical cases in the one area and 65 in the other.) In the majority of County Boroughs the district nursing associations do not undertake midwifery and maternity nursing, but some is done in twenty-eight of them. The recent Report of the Joint Council of Midwifery states that 'Only a small proportion of midwifery in urban and industrial areas is at present carried on by midwives in the employ of Nursing Associations, and then usually in connection with training.' In London very

little maternity work is done and only seventeen midwives were employed by London nursing associations at the end of 1934.

The financial resources available for supporting an association's midwifery service are the fees of patients, grants from public authorities, and the general receipts of the association in voluntary contributions and interest on any capital possessed. The fees charged vary, in general, between about 20s and 42s, and the general policy of associations is to charge the ordinary fee of the district, though this is not always the case. Patients can usually afford some payment as the great majority of them receive the maternity benefit of £2 (in cases where the wife as well as the husband is or has recently been insured, £4) under the National Health Insurance scheme. In many areas the associations have provident membership schemes, similar to those described in the last chapter, and the fees are lower to members than to non-members.

#### GRANTS FROM PUBLIC AUTHORITIES

Prior to the Midwives Act, 1936, public authorities might aid the midwifery service of district nursing associations in a variety of ways.

(1) The powers of the Poor Law Authority include the power to pay for the services of a midwife to a destitute person, if rendered on the recommendation of the medical officer.

(2) Under the Education Act of 1902, the councils of Counties and County Boroughs were empowered to give grants to voluntary associations or create scholarships for the purpose of training district nurses or training them as midwives. (This provision renewed an already existing power.) The Midwives Act, 1928, empowered local supervising authorities to contribute to the cost of training midwives. In 1925 the grants previously payable by the Board of Education to recognized training institutions for midwives became payable instead by the Ministry of Health.

The present position with regard to training grants is:

(a) Grants are payable by the Ministry of Health to recognized training institutions in aid of the training of midwives,

and for the further instruction of midwives already in practice. In the year 1934-5, seventy-one institutions in England and Wales were recognized for training purposes and grants totalling £21,894 were paid to them eight whole-time post-certificate courses for midwives were approved and grants of £458 paid in respect of them

(b) Grants are paid by some County Councils to County Nursing Associations for the training of midwives (e.g. the East Suffolk County Council made a grant of £225 in 1934-5), and in some counties a grant is given for the midwifery service in general, out of which some money is allotted for training. The balance of the cost of training a candidate is usually borne by the County Association on condition that the midwife, when trained, works in its area for a certain period. (For example, in Oxfordshire, the cost of training a nurse-midwife is about £100, of which the County Council pays £30 and the Oxfordshire Nursing Federation the rest. The candidate promises to work in the county for three years.)

(3) Apart from training grants public authorities aid the actual midwifery service in various ways. The Maternity and Child Welfare Act, 1918, and the regulations made under it empowered local authorities for maternity and child welfare to themselves appoint municipal midwives, where necessary, and to aid the midwifery service in various other ways. Some of these powers have been extensively used, but, as far as I can ascertain, grants for midwifery are hardly ever made to nursing associations by authorities which are not also Local Supervising Authorities under the Midwives Acts.

Since 1918 the Ministry of Health (formerly the Local Government Board) has been empowered to pay grants, in accordance with regulations laid down, in respect of various midwifery services. Before the Local Government Act of 1929 grants were paid by the Ministry in some cases direct to nursing associations and in some cases to County Councils which undertook some financial responsibility for the maintenance of the midwifery service in their areas. The basis of grant in 1929, according to the Report of the Departmental Committee on the Training and Employment of Midwives, was that in urban areas a grant was made of half the deficit on a domiciliary midwifery service maintained

by an association approved by the Minister for the purpose. In rural areas grants were made in respect of (a) the midwifery and maternity cases attended by midwives employed by district nursing associations affiliated to the county nursing association, and by emergency midwives on the staff of the county nursing associations, (b) the administrative expenses of the county nursing association attributable to midwifery, (c) the cost of establishing new district nursing associations. (In addition to (b) many County Associations receive part of the salary of the County Superintendent of nurses from public funds by virtue of the fact that she is also the person appointed by the County Council as Inspector of Midwives under the Midwives Acts.) The total amount of grants from the Ministry of Health to voluntary associations for midwifery (excluding grants to training institutions) was £30,664 in the year 1929-30, and it had been at about that level in the three previous years. The Annual Reports of the Ministry for the eight years or so prior to the Local Government Act show that it was very concerned that the whole country should be covered by a service of competent midwives. Each year the Report showed the number of new district nursing associations started and the proportion of the population still uncovered. As was mentioned earlier in this chapter, the figures showed that in the eight years 1921-8 the proportion of the rural population of England (not including Wales) for whom trained midwives were available increased from 68 per cent to 82 per cent.

After the Local Government Act of 1929 all midwifery grants to voluntary organizations, except grants to training institutions, were paid by Local Authorities. As a result of this Act, Local Authorities ceased to receive special midwifery grants from the central government, as all special grants for public health services were replaced by the consolidated block grants paid under the Act. In general, grants continued to be made by Local Authorities for the same purposes in connection with midwifery services as before the Act.

#### THE MIDWIVES ACT, 1936

The whole position with regard to midwifery and maternity nursing has been profoundly changed by the Midwives Act, 1936.

This Act followed closely the recommendations in the Report of the Joint Council of Midwifery, 1935. This Report estimated that out of 15,442 midwives actually practising 6,255 were salaried and 9,187 independent. It considered that the remuneration of most independent midwives was entirely inadequate, and recommended that a salaried midwives' service should be established under the appropriate authority in all areas not already served by salaried midwives, because in order to improve the efficiency and status of the profession it was necessary to improve the remuneration and other conditions of work of midwives.

The main provisions of the Act are as follows —

(a) It is the duty of every local supervising authority to secure that an adequate number of salaried midwives is available in its area to attend on women in their homes either as midwives or maternity nurses. The supervising authority can fulfil its obligation either by making arrangements with the local maternity and child welfare authorities or with voluntary organizations for the employment of full-time midwives or by itself employing them. Grants will be paid by the Central Government, amounting to half the additional expense incurred, with adjustments according to the financial circumstances of the local authority in question.

(b) Independent midwives who either surrender their certificates voluntarily or are retired compulsorily by reason of age or infirmity are entitled to compensation at certain stipulated rates based on the individual midwife's average yearly earnings.

(c) When the Minister of Health is satisfied that any district has secured, in pursuance of the Act, the provision of an adequate service of domiciliary midwives he may make an order prohibiting any woman without certain qualifications from engaging in maternity nursing.

It seems clear that the object of the Act is not to supersede the midwifery service of district nursing associations by publicly employed midwives. Local supervising authorities must consult with all the voluntary organizations in their area employing domiciliary midwives before submitting their proposals to the Minister, and the probable effect will be to increase the support given to the midwifery service of these

organizations from public funds. The Report of the Joint Council of Midwifery stated 'The relatively low maternal mortality rates' obtaining in those areas at present served by salaried nurse-midwives provided by Nursing Associations or by hospitals is well known, and the object of this Committee in recommending the institution of a Municipal Service is to extend the advantages so clearly exemplified in these districts to areas which do not yet possess them. Those who have experience of conditions in rural areas, where sufficient well-to-do and charitable persons exist to enable local Nursing Associations to employ suitable midwives at an adequate salary, working under constant and skilled supervision, are convinced that the provision of midwives in rural areas should be left in the hands of the County Nursing Associations. With this view the Committee concurs. The Report recommended that, where necessary, grants should be made from public funds to district nursing associations for the specific purpose of (a) extending their service so as to cover adequately every part of the area allotted to them, and (b) paying the same rates of pay and providing pensions on the same scale as are paid and provided by the Local Supervising Authorities to midwives employed directly by them. In connection with (a) it was estimated by the Queen's Institute that about 200 additional midwives were required to meet completely the needs of rural areas in the forty-two counties in which there were county nursing associations affiliated to the Institute.

With regard to the effect of the Act on district nursing associations I have received some information from the Queen's Institute as to the position up to July 1937. The General Superintendent of the Institute states: 'In every County complete schemes have been drawn up and in the majority of cases the balance has been decidedly in favour of voluntary organizations. This will mean that the salaries of the midwives will be improved, pension arrangements secured, larger administrative grants, and, therefore, we hope a more adequate supply of applicants for posts. In some cases the grants are not so good and in the Urban Districts the tendency has been on the part of Councils with strong political views to take over the midwifery of the Nursing



Association and to provide a Municipal Service. In others the Association has been asked not only to continue its present work but to extend it to include the midwifery and maternity service of the Borough. As some of the schemes are awaiting approval by the Ministry I cannot be definite as to the whole country up to the present, but we have been satisfied that we have gained far more than we have lost.

### 3 PUBLIC HEALTH WORK

District nurses are employed in various places in two major branches of public health work—school nursing and work in connection with maternity and child welfare—besides various minor departments of work.

#### SCHOOL NURSING

The first school doctor was appointed by the London School Board in 1890, but school nurses were first employed by district nursing associations and other voluntary organizations. The pioneer was the Metropolitan Nursing Association, which started school nursing in the Drury Lane district of London in 1892. Six years later the London School Nurses' Society was founded, which carried on the work until it was taken over by the London County Council in 1904. In Liverpool the work was started privately in 1895 and taken over by the district nursing association about 1902. As was described in Chapter XIII, the Birmingham Society started school nursing in 1900, and in several other places district nurses were doing similar work before the Act of 1907.

The Education (Administrative Provisions) Act, 1907, imposed on all local education authorities the duty of providing for the medical inspection of children in the elementary schools. It also empowered the authorities to make such arrangements as the Board of Education might sanction for attending to the health and physical condition of the children. In the exercise of these powers the authorities might co-operate with and assist voluntary agencies, and advantage was soon taken of this provision by many authorities, who made arrangements with nursing associations that their nurses should assist the doctors at the medical inspections.

and the resulting home visiting. Already in 1909 thirty-seven associations affiliated to the Queen's Institute and local associations in six affiliated counties had undertaken work for the education authority in return for grants varying from £100 per annum per nurse to 9d per child visited at home. The arrangements between the Banbury Association and the Banbury Education Committee, described in Chapter XIV, are an example of the position at this date.

The changes described in the arrangements in Banbury are also an example of how, in many places, as the service developed, education authorities came to employ their own staff, either as full-time school nurses, or combining school nursing with other kinds of public health work. The present position is that the use of district nurses for school medical work is almost confined to areas coming under county education authorities (and to only some of these), with the exception of London, where district nurses are employed for certain special purposes.

The Annual Report of the Chief Medical Officer of the Board of Education shows that, for the year 1934, out of a total of 5,728 school nurses, 2,308 were district nurses not employed directly by the education authorities. Thus district nurses were 40 per cent of the total number of school nurses, though, as most of them did only part-time school work, while many of the others were full-time, they did not do nearly as much as 40 per cent of the total work. Of the 3,420 other school nurses, 1,472 gave their full time to the school medical service, 1,849 gave the rest of their time to other public health work, and 99 gave the rest of their time to private practice, etc.

Of the 2,308 district nurses employed, 99 were employed in London, 7 by County Boroughs, 4 by Municipal Borough Education Authorities, and 2,198 by County Education Authorities. There is considerable variation in the arrangements and scales of grants in different counties. The following scheme will serve as an example.

In Anglesey in 1933 work was done by all the twenty-one associations in the county (in one case attendance at minor ailment clinics only). 1,279 visits were paid to sixty-seven schools in connection with medical inspection; 41,312

scholars were examined, 731 health talks were given to scholars, and 2,138 visits were paid to homes. For this work the scale of payment was 30s per school, 2s per physically defective scholar in urban schools and 3s in rural schools, plus an addition of 25 per cent to this total. The total amount of grants for this work was £217. In addition there were grants for attendance at schools and clinics for the treatment of minor ailments—2s per visit to schools in rural areas, 5s per attendance at clinics in urban areas. A total of 1,130 visits were paid for the treatment of minor ailments, and the total grant for this purpose was £142.

In most cases where district nurses act as school nurses they are only doing so for part of their time. In the County of London the position is different. District nurses are not employed in London for work at the schools or for any work in connection with medical inspections, but only in connection with the treatment of minor ailments and otorrhœa. The position in 1931, according to Dr Hogarth's survey, was that between sixty and seventy nurses were engaged in this work, the London County Council paying the Associations which employed them £170 per nurse per annum. Besides attending at the clinics, the nurses visit the homes of children whose attendance at the centre is irregular. In some cases the Associations employ special nurses for the work, but even when this is not the case, the work of the clinics occupies all, or almost all, of the time of the nurses concerned.

#### MATERNITY AND CHILD WELFARE WORK

Maternity and child welfare work, like school nursing, was pioneered by voluntary organizations, but in this case not frequently by district nursing associations. The Notification of Births Act, 1907, which was an adoptive Act, gave a great stimulus to infant welfare work in the areas where it was adopted, and the Act was made obligatory in 1915. In 1914 a Local Government Board circular indicated lines on which the work should be developed and stated that application might be made for Government grants up to 50 per cent. of approved expenditure. The Maternity and Child Welfare Act, 1918, gave wide powers to local authorities

to provide a variety of services for expectant and nursing mothers and for children under five

According to the Annual Report of the Ministry of Health, there were, at the end of March 1935, a total of 5,575 health visitors engaged in maternity and child welfare work in England and Wales. Of these, 3,013 were employed by local authorities (for this work alone, or for this work in combination with other public health work) and 2,562 were employed by voluntary associations. These latter were not all district nurses, but the great majority were. At the end of March 1930, the last date at which the figures were distinguished, of the 2,113 health visitors, who at that date were employed by voluntary organizations, 1,773 were district nurses (The other 340 were 'employed by voluntary associations in connection with infant welfare centres'). Since that date the numbers of both publicly employed and voluntarily employed health visitors has increased considerably—the publicly employed from 2,554 to 3,013, the voluntarily employed from 2,113 to 2,562. Although the number employed voluntarily was, in March 1935, about 46 per cent. of the total number, most of them were engaged in maternity and child welfare work only for a small proportion of their time, and their 'equivalent of whole-time service' was only 21 per cent. of that of the whole number (534 out of 2,602). It may be noted that, according to this estimate, the district nurses and other health visitors employed by voluntary organizations devoted, on an average, about one-fifth of their time to this work.

No figures are given as to the distribution of the voluntarily employed visitors in different types of areas. With a few exceptions, they are not employed in London. The work of district nurses in home health visiting is nearly all in rural areas or small towns, but in large towns they sometimes assist at infant welfare centres. The following is an example of a scheme in a county area.

In East Suffolk in the year 1934-5 health visiting for the County Council was carried out by district nursing associations in every district except one of the Administrative County. The number of visits was 48,993. Nurses were working at infant welfare centres in fourteen places. The

grant for health visiting was up to £10 per annum per nurse according to salary

#### OTHER PUBLIC HEALTH WORK

In addition to the two branches of work just described, district nurses in various places do some or all of the following branches of health work

Attendance at tuberculosis dispensaries and home visiting of cases of tuberculosis (the home nursing of tuberculosis was included in the section on general nursing)

Work as Infant Life Protection Visitors under the Children's Acts, i.e. visiting of children under the age of nine taken in for reward

Visiting of mental defectives

#### THE GENERAL POSITION WITH REGARD TO PUBLIC HEALTH WORK

In the majority of cases where district nurses are employed as school nurses they are also employed for maternity and child welfare work and vice versa. The typical district nurse doing public health work is the nurse employed by a village association, combining both branches of public health work (and in addition often some or all of the minor branches listed above) with midwifery and maternity nursing and general nursing.

In the Queen's Institute Survey it was estimated that a nurse doing such work could cover a population of 3,000. The Survey showed the position in 1934 with regard to the Administrative Counties in which all, or any part of, the county was covered by nurses doing this combination of work (There were no cases in London or the County Boroughs). Of the total population of 17·1 million in administrative Counties nursed by associations affiliated to the County Associations, 5·7 million—33 per cent—were nursed by nurses doing this combination of work. (There is no information as to this matter with regard to the 3·4 million nursed by associations not affiliated.) There were no affiliated associations doing this combination of work in sixteen counties in England—Derbyshire, Devonshire, Hampshire, Lancashire,

Leicestershire, Holland (Lincolnshire), Lindsey (Lincolnshire), Middlesex, Northamptonshire, Nottinghamshire, Oxfordshire, Soke of Peterborough, Rutland, Smiley, Warwickshire, East Riding of Yorkshire. At the other end of the scale, in six counties all the affiliated associations were combining public health work with midwifery and general nursing—Bedfordshire, Essex, Huntingdonshire, East Suffolk, Westmorland, and the Isle of Wight. In the twenty-six other counties there were some districts where it was done, in several of the counties over a large part of the area. In Wales there were no areas where it was done in Flintshire, Merionethshire, and Monmouthshire, and very few in Glamorganshire. It was done in all affiliated areas in Anglesey, Carmarthenshire, Montgomeryshire, Pembrokeshire, and Radnorshire, and in a considerable proportion of areas in the other four counties.

With the information at my disposal I cannot give conclusive reasons why some public health and education authorities in rural areas prefer to use the services of district nurses, while some prefer to employ their own staff, but the following are some reasons for both courses. As reasons in favour of employing district nurses are the facts: (1) The cases to be visited are widely scattered, so that specialist whole-time health visitors must spend a great deal of time in travelling, even when they combine all branches of public health work, as they often do. (2) The fact that the district nurse health visitor has friendly contacts with many of the families in her other capacities as nurse and midwife helps her by giving her the confidence of the families visited and often the possession of much relevant information, and there is no hesitation in consulting her about small ailments. This advantage is especially marked when she visits as infant health visitor babies already nursed as midwife or maternity nurse. The disadvantage of using district nurse health visitors is that they are not so well trained for their public health work as specialist health visitors. All full-time health visitors appointed by local authorities for the first time must hold the Health Visitor's Certificate, and many of them are in addition fully trained nurses. On the other hand many district nurse health visitors have no training beyond that of the village nurse-midwife, with sometimes one or two months'

training in public health work in addition. Besides this the district nurse has less chance of keeping expert in public health work through intensive practice, and cannot give her first attention to it when there is much urgent nursing or midwifery to be done.

## CHAPTER XVII

### THE INCOME OF DISTRICT NURSING ASSOCIATIONS

#### THE QUEEN'S INSTITUTE SURVEY FIGURES OF THE INCOME OF DISTRICT NURSING ASSOCIATIONS IN ENGLAND AND WALES IN 1934

IN the 'Survey of District Nursing in England and Wales,' published by the Queen's Institute, figures are given of the amounts in 1934 of income from different sources in the district nursing associations in the separate counties and in the whole country. These figures are based on returns from 3,169 associations employing 5,106 nurses. The total number of nurses employed in the country was 7,285, so that the financial figures cover associations employing 70 per cent of the nurses.

In this statement of sources of income interest on investments is not classified separately, but is included under the heading 'Other Sources'. Legacies are not mentioned separately but are included under 'Voluntary subscriptions and donations'. The Survey notes that 'accurate figures have been given as far as possible but in some cases they are unobtainable or incomplete'. It also gives the important caution that 'The totals received from provident subscriptions are underestimated, as in many instances they were classified in the local annual reports under voluntary subscriptions, and cannot, therefore, be given separately'.

The first of the two following tables summarizes the Survey figures for the whole of England and Wales. The second table selects ten counties (which, in these figures, include the associated County Boroughs) as examples of different types of areas in England and in Wales. The counties chosen are London, Middlesex as an example of an area of Outer London, County Durham, Lancashire,



Staffordshire, and Glamorganshire as examples of industrial counties, and Devonshire, Oxfordshire, Shropshire, and Anglesey as examples of agricultural counties

It will be seen from the tables that the total income of district nursing associations in the country is at least one

**SOURCES OF INCOME OF DISTRICT NURSING ASSOCIATIONS  
IN ENGLAND AND WALES IN 1934**  
(Number of Associations 3169)

	Amount	Proportion of Total Income.
	£000s.	%
Total Income . . . . .	1060	100
Voluntary Subscriptions and Donations . . . . .	265	25
Special Efforts . . . . .	91	9
Local and other Charities . . . . .	25	2
<i>Total Charitable Gifts . . . . .</i>	<i>380</i>	<i>36</i>
Patients' Payments . . . . .	163	15
Provident Subscriptions . . . . .	253	24
<i>Total Payments by Patients and their Societies for Services Rendered</i>	<i>416</i>	<i>40</i>
Public Grants . . . . .	181	17
Other Sources . . . . .	82	8

million pounds. Of this amount less than a fifth is contributed from rates and taxes. Three quarters is raised in voluntary contributions either of a charitable nature or in return for services rendered, and these two classes of contributions are of nearly equal importance.

SOURCES OF INCOME OF DISTRICT NURSING ASSOCIATIONS IN TEN COUNTIES IN 1934

	England and Wales		London		Middlesex		County Durham		Lancashire		Staffordshire		Glamorgan-shire		Devonshire		Oxfordshire		Shropshire		Anglesey	
	3169	£000	34	£000	28	£000	112	£000	145	£000	56	£000	41	£000	159	£000	55	£000	99	£000	20	£000
Total Income		1060		78		19		42		90		16		19		38		13		19		6
Proportion of Income from		%		%		%		%		%		%		%		%		%		%		%
Voluntary Subscriptions and Donations	25		24		11		14		25		38		18		13		28		13		23	
Special Efforts	9		3		11		7		9		15		10		17		13		13		20	
Local and Other Charities	2		4		3		22		7		6		4		3		4		4		4	
Total Charitable Gifts	36		31		24		22		41		58		31		32		44		31		47	
Patients' Payments	15		16		25		13		19		12		11		20		23		13		11	
Provident Subscriptions	24		7		37		44		19		1		38		23		11		26		24	
Total Payments by Patients and their Societies for Services Rendered	40		23		62		57		38		14		49		43		34		38		34	
Public Grants	17		36		10		17		10		12		13		17		15		25		15	
Other Sources	8		9		3		5		11		17		7		8		7		6		4	

The proportion of income derived from public grants varies considerably in different counties. As was shown in the last chapter there are several kinds of grants which can legally be given by local authorities, and there is much variation between different authorities as to the use made of their legal powers and as to the generosity of the grants when given. The proportion of income from grants is high in London, here the London County Council makes a large grant in payment for the work done by district nurses at the Education Committee's minor ailment clinics. It is also fairly high in Shropshire, where a large majority of the nurses act as both health visitors and school nurses for the County Council, and where also the midwifery grant is generous. The proportion from grants is considerably below the average for the whole country in Middlesex and in three out of four of the industrial counties.

The amount of income received in grants depends not only upon the generosity of the local authorities concerned but upon the types of work done by the associations. All associations do general nursing and all are therefore eligible for public assistance grants and grants for the nursing of notifiable diseases and cases under the Maternity and Child Welfare Act. But many associations do no midwifery work and many do no public health work and are therefore not eligible for the grants for these purposes. With regard to the counties covered in the table there is hardly any public health work done in Middlesex, Durham, Lancashire, Glamorganshire, Devonshire, and Oxfordshire. In Shropshire and Anglesey, on the other hand, a great deal of work is done. In Staffordshire some work is done and in London one particular branch of work—attendance at minor ailment centres. With regard to midwifery hardly any work is done in London, some work is done in Middlesex, a good deal of work is done in all the four industrial counties, and work is done in the whole area of the four agricultural counties (with the exception of the County Borough of Oxford). With regard to Durham and Glamorganshire considerable grants have been given to district nursing in these areas under the Special Areas Act, 1934, but these grants are too recent to affect to any considerable extent the accounts of associations in 1934.

### FURTHER INFORMATION ABOUT THE INCOME OF DISTRICT NURSING ASSOCIATIONS IN CERTAIN AREAS IN 1934

In the following pages some additional information is given with regard to the income in 1934 of district nursing associations in London, in Liverpool and Manchester, the two cities comparable with Birmingham in size of population; and in West Suffolk as representing the position in a typical rural area. The figures are based on the information in the annual reports of the associations.

#### THE COUNTY OF LONDON

The Survey figures show that in London the proportion of income received from provident subscriptions was only about a third of that for the country as a whole, and the proportion from public grants was more than twice as high as the average.

Dr Margaret Hogarth in her 'Survey of District Nursing in the Administrative County of London,' made for the LCC in 1931, makes various remarks about the financial position of the London Associations. She notes with regard to subscriptions and donations that 'Few associations are well endowed, the majority have to put forth tremendous efforts to secure funds sufficient to keep things going. Subscriptions and donations for nursing, as for other charitable institutions, are decreasing, while side by side with this decrease there may be an increase in the nursing needs of the area. A not inconsiderable amount of income is received from collections and funds, such as Alexandra Day collection, Hospital Saturday Fund, Hospital Sunday Fund, and charitable funds distributed by the Central Council for District Nursing.'

She notes that income from contributions and patients' payments have tended to decrease with the growing popularity of the Hospitals Saving Association, which guarantees free hospital treatment in return for weekly payments to it, but which does not include district nursing in the benefits provided nor contribute to the nursing associations. The Ranyard Nurses have a provident system of their own, and

so have a few other societies, but there is apparently no such scheme in many London associations, including the Metropolitan District Nursing Association, one of the largest associations. With regard to patients' payments she notes that 'Many associations make no actual demand for payment, relying on the patient's good feeling and sense of gratitude, others have printed a definite statement as to the cost per visit which they leave at the patient's house to encourage contributions, whilst others arrange for the nurses to have collection cards on which they enter contributions received.'

The Public Assistance Committee of the London County Council now makes a grant of £6,000 per annum, which is distributed to the various district nursing associations working in the County of London through the Central Council for District Nursing in London.

The largest single association in London, the Ranyard Nurses, had in 1934 a total income of about £17,000. Of this income 35 per cent came from charitable contributions—28 per cent directly and 7 per cent through central funds. 35 per cent came from patients and their societies for services rendered—6 per cent from individual patients, 26 per cent from provident subscriptions, and 1 per cent in National Health Insurance benefits from Approved Societies. 29 per cent came from public grants—7 per cent from the L.C.C. public assistance grant, 17 per cent from the L.C.C. for the work of Ranyard Nurses in connection with the Education Committee's minor ailment centres, and 5 per cent from Metropolitan Borough Councils for the nursing of notifiable diseases and cases under the Maternity and Child Welfare Act. Less than 1 per cent. of total income was received in interest on investments.

#### LIVERPOOL

The Liverpool Queen Victoria District Nursing Association covers the whole of Liverpool except for districts covered by two small associations each employing only one nurse.

The total ordinary income of the Association in 1934 was about £9,500. Of this income 23 per cent. came from charit-

able contributions—22 per cent directly and 1 per cent. from central funds 40 per cent came from patients and their societies for services rendered—13 per cent from individual patients, 24 per cent from provident subscriptions, and 2 per cent in National Health Insurance benefits from Approved Societies 14 per cent was received in grants from public authorities—4 per cent from the Public Assistance Committee, 4 per cent for work in connection with tuberculosis, 3 per cent for work at minor ailment clinics for school children, and 2 per cent for infant welfare work 24 per cent was received in interest on investments

The outstanding feature of the finance of this Association is the large proportion of income represented by receipts from investments, to the best of my knowledge such large proportionate receipts from interest are very exceptional in the finance of district nursing

The receipts from provident subscriptions come from the '1d. in the £' contributory scheme organized by the Merseyside Hospitals Council this scheme includes district nursing as well as hospital treatment in the benefits provided

#### MANCHESTER AND SALFORD

The Manchester and Salford District Nursing Institution covers Manchester and Salford except for districts covered by seven much smaller associations (These associations in 1934 together employed eleven nurses and the Institution employed sixty)

The total ordinary income of the Institution in the year 1934-35 was about £11,100 Of this income 37 per cent came from charitable contributions 21 per cent. directly, 8 per cent, from central funds, and 8 per cent from local endowed charities 34 per cent came from patients and their societies for services rendered—16 per cent from individual patients (of which about a quarter was recorded as being payments for midwifery and maternity nursing services), 8 per cent from the Manchester and Salford Hospital Saturday and Convalescent Homes Fund, 6 per cent from a provident scheme organized by the Institution in the Hulme and Moss Side District, 4 per cent in National Health Insurance Benefits from Approved Societies, and

under 1 per cent from payments for nurses' attendance at works 11 per cent was received in grants from public authorities—5 per cent from the Manchester Public Assistance Committee, 5 per cent from the maternity and child welfare departments of Manchester and Salford, less than 1 per cent from Salford for the training of midwives, and less than 1 per cent from Salford for the nursing of notifiable diseases 14 per cent of total ordinary income was received in interest on investments, and the remaining 4 per cent of income was in miscellaneous receipts

It may be noted that though a grant of over £800 was made to the Institution from the Hospital Saturday Fund—the hospital contributory scheme for the district—the importance of this grant as a source of income was not nearly so great as in either Liverpool or Birmingham The Institution had its own provident scheme in one of its districts, and in 1935 it was organizing a scheme in another district into which it was just extending its work

#### WEST SUFFOLK

The Annual Report of the Suffolk Nursing Association for the year 1934–35 gives for both the administrative counties of East and West Suffolk a very clear tabulated statement of the accounts of all the district nursing associations affiliated to it

From the statement for West Suffolk I have prepared the following Table with the object of showing the sources of income of a group of rural village associations The Table covers all the affiliated associations in West Suffolk with the exception of five associations in Boroughs and Urban Districts, one other association which employs more than one nurse, and one other association where the nurse does no public health work The thirty-two remaining associations are all in rural areas, each association employs only one nurse, and in all cases the nurses act as health visitors for the County Council They therefore form a homogeneous group, and the average figures given in the first two columns of the Table may be taken as representing the receipts of a typical village nursing association in a county where the nurses do public health work as well as general nursing and midwifery and

maternity nursing (In comparing these figures with those for certain Oxfordshire village associations given in Chapter XV it should be remembered that in Oxfordshire the district nurses do no public health work.) From the information given in the Report it is not possible to discriminate between different types of public grant to this particular group of associations. The total grants received by the Suffolk Association from the West Suffolk County Council amounted to

VILLAGE DISTRICT NURSING ASSOCIATIONS IN WEST SUFFOLK  
SOURCES OF INCOME OF 32 ASSOCIATIONS IN THE YEAR 1934-35

	Average Association		Range between Individual Associations	
	£ 178	Proportion of Receipts	Minimum	Maximum
		% 100	£ 114	£ 268
<b>Total Receipts</b>				
<i>Voluntary Subscriptions, Donations, etc</i>	69	39	7	163
Midwifery Fees	12	7	2	36
Maternity Nursing Fees	4	2	Nil	13
Provident and other Patients' payments not entered above	52	29	Nil	118
<i>Total Payments by Patients for Services Rendered</i>	67	38		
<i>Grants from County Council</i>	41	23	34	82

£1,802, of which £1,177 (65 per cent) was for health visiting, £455 (25 per cent) was for midwifery—£180 of this was a grant for the provision of new midwives—and £170 (9 per cent) was a grant from the Public Assistance Committee.

It is not possible to distinguish the payments made through provident schemes from payments by individual patients, but in the figures for West Suffolk given in the Queen's Institute Survey (which include also the urban associations), provident subscriptions are entered separately and the amount of these is 64 per cent of the total payments by patients for services rendered. It therefore seems safe to assume that, when midwifery fees have been separately classified, the



greater part of the remaining payments by patients are in the form of provident subscriptions

• There is no separate classification of interest either in the figures in the Suffolk Association's report or in those in the Survey, and any sums received in interest are presumably included in both cases under voluntary subscriptions and donations

It is interesting to note how small a financial unit is the average village association, and to realize that district nursing organization includes financial units which vary in size from the £178 income of the average West Suffolk association to the £17,700 income of the Birmingham Association—almost 100 times as great

#### PAYMENTS FROM APPROVED SOCIETIES

As was noted in the chapter on Birmingham, when the National Insurance Act of 1911 was passed nursing was not at first included as a possible benefit under the scheme. In 1913 there was a conference in London between delegates of district nursing associations and of Approved Societies, and this conference decided to approach the Government with a view to persuading them to include nursing as a benefit in the next amending Act. In the amending Act of 1920 domiciliary nursing was included as an 'additional benefit,' and in 1921 the Queen's Institute concluded an agreement with two large Approved Societies

All payments from Approved Societies are made to the Queen's Institute and distributed by them to the associations responsible for the nursing of the members for whom grants are paid. The position in 1933 was that there were two schemes arranged with Approved Societies. One scheme, which included about sixteen societies, provided for the nursing of members entitled to additional benefits by district nurses in return for a payment of 1s 4d a visit for the first thirty visits and then at a rate not exceeding 5s a week. The second scheme, which included about eight societies, provided nursing under the same conditions in return for the payment of 1s per visit. In addition, the associations were allowed to charge the patients concerned not more than 4d a visit. In 1934 there had been minor alterations in these schemes

and five more Approved Societies had joined them. In that year the total amount received in payments from Approved Societies was £7,922, which was under 1 per cent of the total income of district nursing associations in that year. (A large proportion of this amount was received from two societies.)

### PROVIDENT SCHEMES

As was shown above, the receipts from provident subscriptions in 1934 amounted to at least £250,000, and accounted for 24 per cent of the total income of district nursing associations and for 60 per cent of the total payments from patients.

There are two main types of provident schemes. One is the scheme organized by a district nursing association for the provision of general nursing services to the members either completely free or at low rates, and of midwifery at much lower rates for members than for others. The other is the scheme organized by some form of hospital contributory association which includes district nursing as one of the benefits provided for members.

(1) Two examples of the first type of scheme in rural villages were given in Chapter XV. (Of these the South Newington Association's scheme is the more typical, as the Heythrop Association's scheme included payment for resident 'cottage benefit' nursing.) The details of schemes vary in different places, but schemes of much the same type as that described for South Newington exist in a very large number of rural areas. In these areas the bulk of subscriptions have to be collected from house to house, but the associations can usually find collectors willing to do the work voluntarily.

In towns a large number of subscriptions can be collected through factories and other places of work and through groups of various kinds. Paid collectors are often employed in towns. The Leicester District Nursing Association's provident contributory scheme is a good example of a nursing provident scheme in a large town. In this scheme there are four ways in which contributions can be made. (1)  $\frac{1}{2}$ d per week (in practice 1d per fortnight) paid through the contributor's place of employment entitles him to free nursing services for himself and his dependants. (2)  $\frac{1}{2}$ d per week can be contributed through a women's meeting—church, social,

or political (3) Members of the Public Medical Service pay 3d per month—this is collected by the agents of this Service. (4) In the home scheme, which is intended for those who are not weekly wage earners, payments of 6s a year cover the contributor and his dependants and payments of 10s a year cover also one maid. These payments are collected by the agents of the Association annually, half-yearly, or quarterly. In 1934 the Leicester Association received £7,620 from the whole of its provident scheme—82 per cent of its total income. Of the total sum £5,878 was received in contributions paid through factories and other places of employment, and £1,344 was received from the home scheme (£196 was paid in commission to collectors for the home scheme). Much smaller amounts were received from women's organizations and from the Public Medical Service scheme.

(2) The Birmingham Hospitals Contributory Scheme, described in Chapter XIII, is a good example of a hospital contributory scheme which includes district nursing among the benefits provided to members. Some information collected by P E P (Political and Economic Planning) shows that in 1934 at least twenty-five hospital contributory schemes, with a membership of about 1,300,000, included district nursing as a benefit available to members. The schemes vary as to the generosity of their grants to district nursing—the Birmingham scheme is exceptionally generous. There is evidence in some areas that where separate schemes exist for hospitals and for district nursing the competition affects the nursing schemes adversely. There is a good case to be made for co-operation in the matter between hospital and district nursing organizations, particularly in view of the work done by district nurses for cases discharged from hospital.

It should be noted with regard to all provident schemes which affect district nursing that while these schemes give certain definite financial advantages to their members they do not relieve the district nursing associations from the obligation to give free nursing to necessitous cases, whether members or not. (The acceptance of this obligation is a rule with regard to all associations affiliated to the Queen's Institute.) However, when non-members can afford to pay an appropriate charge is made to them.

It should also be noted that associations affiliated to the Queen's Institute are expected not to encroach upon the work of private visiting nurses. Partly for this reason the membership of provident schemes may be limited to those below a certain income level.

### CENTRAL VERSUS LOCAL FINANCE

The following paragraphs discuss the question of the extent to which district nursing is financed by those living in the immediate locality in which the nurse works and the extent to which the financial burden is spread over a larger area. My information on this point is very incomplete but certain general statements can be made.

Individual patients' payments are obviously local. Payments from Approved Societies are made on behalf of individual patients and the same is often true of payments from hospital contributory schemes, so that in both these cases the amount of total payment to the association is related to the number of contributing members in the association's area.

Public grants are made by the local council in the case of County Boroughs, and in this case the financial burden is spread over the whole area of the Borough. In Administrative Counties the public assistance grants and (in most cases) the grants for midwifery are made by the County Council, and the financial burden of these grants is spread over the county as a whole. These grants are apportioned between the local associations according to different principles in different counties. They may be distributed strictly in accordance with the amount of the relevant work done by the individual associations, or they may be distributed according to the relative financial needs of the associations, or there may be a combination of these two principles of distribution. Grants for public health work and for the nursing of notifiable diseases and cases under the Maternity and Child Welfare Act may be made by either the County Council or by the local Borough or District Council. To the extent that the expenditure of local authorities is aided by grants from taxation the burden of their payments to nursing associations

is spread not only over the area of the local authority but over the country as a whole. In the special case of the grants to district nursing in depressed areas under the Special Areas Act, 1934, there is a definite financial subsidy to the service in these areas from the resources of the whole country.

With regard to charitable gifts the vast majority of donors are local residents, though over the country as a whole there are probably large numbers of individual donations from persons outside the areas of the associations, who for some reason have an interest in the area.

In the area covered by any one association there is complete or partial shifting of the financial burden over the whole area. In the case of large towns such as Birmingham this means that the poorer areas of the town are subsidized by the richer (See page 234). This cannot happen to the same extent over the areas of counties because the small local associations are financially autonomous, but a good deal is done by some county nursing associations to give financial assistance to their poorer affiliated associations. This is done sometimes by the method of distributing some of the County Council grants paid through the county association, so as to give more to the poorer local associations. Also where the county association has an adequate income from other sources it sometimes uses part of this to help poor local associations or to aid the establishment of new associations. Some county associations give financial assistance by paying a proportion of the superannuation contributions for the nurses employed (For example, this is done in Oxfordshire—see page 237). In addition to any financial help given the county associations give valuable assistance to their affiliated associations in various ways which were noted in the last chapter.

The help given by the Queen's Institute to county and district associations is important in many ways but it includes hardly any direct financial assistance.

#### SUMMARY AND COMPARISON WITH VOLUNTARY HOSPITALS

From the information given in this chapter and in the sections on finance in previous chapters some generalizations

can be made with regard to the present sources of income of district nursing associations and with regard to the changes in the relative importance of these sources over the last forty years

On the average total charitable gifts constituted in 1934 between a third and two-fifths of the total income of district nursing associations. Payments from patients and their societies amounted to rather more than this—about two-fifths. About a sixth of total income came from public grants. The remainder—between a twelfth and a thirteenth—came from other sources, including interest.

With regard to the changes in these sources of income it has not been possible to give any inclusive figures. Those given in previous chapters for Birmingham and for Banbury show that in both cases practically the whole income forty years ago came from charitable gifts. In Birmingham there was a steady decrease in the proportion from charitable gifts and a steady increase in the proportion of payments from patients and their societies in every decade throughout the period. In Banbury this was true in the decades until 1914 but it has not been true of the decades since. Public grants were of hardly any importance in 1894 and of considerable importance forty years later. I have little doubt that over the country as a whole there has been a decrease in the proportionate importance of charitable gifts and an increase in the importance of payments from patients and their societies not only over the last forty years but in the post-War period. (However, I have not sufficient statistical evidence to prove this general impression.)

The significance of this change is that the function of charity as regards district nursing has ceased to be (as it was forty years ago) that of paying the whole cost of the service for those too poor to contribute in any way and has become that of subsidizing the service. Charity must meet the difference between the cost of the service and the amount which those benefiting can afford to pay either individually or through mutual insurance, plus the amount which public authorities are able and willing to pay on their behalf. A given sum of money in charitable gifts now 'goes much farther' than it would have done forty years ago, because it

is now paying only rather more than a third of the cost of the service instead of the whole cost

There has been another change of great importance about which I have little doubt, though again without sufficient evidence for proof of the statement. Charitable gifts have ceased to be provided solely or preponderantly by the comparatively well-to-do and have come to be provided by all classes of the community. The figures given for house-to-house collections in Birmingham and in Banbury are striking examples of this fact. District nursing has ceased to be a service provided by 'the well-to-do' for 'the poor' and has become a service provided for all who need it and contributed to by all classes of the community according to their means.

Public grants have become of considerable importance, but until 1937 they could only legally be given for certain purposes, and in many cases they do not meet the whole cost of the service for which they are given. They have been of great assistance to the public health and midwifery work of associations, but general nursing work has been left mainly to voluntary finance.

It is interesting to make certain comparisons between the sources of income of district nursing associations and of voluntary hospitals (for the figures for hospitals see Chapter IX in Section II). The total receipts of voluntary hospitals in England and Wales in 1934 were about 14½ million pounds as compared with something over one million pounds for district nursing associations. Of this amount 3½ million pounds was classified as outside ordinary income, and about half of this was received in legacies. In contrast district nursing associations have comparatively little non-recurrent capital expenditure (for which the voluntary hospitals often receive large extraordinary gifts) and they have probably benefited to a comparatively small extent from legacies.

If extraordinary income is excluded, voluntary hospitals received 55 per cent of their ordinary income in payments for services rendered, including public grants, compared with the 57 per cent received by district nursing associations (Public grants were much less important in hospital finance.) This close similarity of proportionate importance did not,

however, apply to the other main sources of income, as voluntary hospitals received only 29 per cent in charitable gifts, compared with the 36 per cent received by district nursing associations. The balance of 16 per cent of the income of voluntary hospitals was received mainly in interest, which was much more important as a source of income than in the case of district nursing associations. However, the main impression made by this comparison is of the great similarity in the general constitution of the ordinary income available for the two health services of voluntary hospitals and district nursing.



## CHAPTER XVIII

### CONCLUSIONS

IN this survey I have been concerned in viewing the organization of district nursing in England and Wales not from the professional standpoint but as an example of a voluntarily organized social service. Up to this point I have tried to treat the subject as objectively as possible, without the introduction of any personal views. In this chapter, on the other hand, I shall give my general impressions on the ground covered and my views on two matters in which I am specially interested.

#### GENERAL IMPRESSIONS ON DISTRICT NURSING ORGANIZATION

As I have studied the printed reports of associations and interviewed those engaged in the work, I have been greatly impressed by the high standard of service aimed at by most of those concerned in the organization of district nursing, by the continuous efforts made to cover the whole area of the country with an adequate service, and by the widespread financial support given by all classes and groups of the population. The early founding of the Queen's Institute and of county associations has given to the district nursing movement a unity and co-ordination which has, unfortunately, been lacking or only recently developed in many other branches of charitable effort. The development of contributory provident schemes and of house-to-house collections of small charitable contributions has enabled the service to draw on the financial support of a very large number of people. Though, as I explain below, I should like to see the personnel of administrators more widely representative of all classes of the population, it seems to me that the organ-

ization of the service is, on the whole, untainted with any spirit of condescension and patronage from richer to poorer, and that district nursing is regarded by its administrators as a desirable social service to be made available to all in accordance with their need for it. The associations responsible for district nursing have given invaluable help to public authorities in several branches of work for which the State has assumed complete or partial responsibility, particularly in the building up of a body of trained midwives and in the development of the school nursing and infant welfare services. In the sphere of general nursing, in which the State has given very little help, they have covered almost the whole country and have provided a service which, though it is not quantitatively adequate, has probably achieved 80 per cent of adequacy.

#### • THE DEMOCRATIZATION OF DISTRICT NURSING ORGANIZATION

Two of the most striking points about the finance of district nursing are the large amounts received in payments for services rendered and the large number of small charitable subscriptions. This means that district nursing associations receive much of their income from working-class households—in individual payments towards the cost of nursing, in contributions to provident schemes, in rates paid to local authorities making grants to district nursing, and in small contributions to house-to-house collections, flag days, etc. This state of affairs contrasts with the position in the early days of the service, when it was financed to a very large extent by the relatively well-to-do.

But although district nursing has ceased to be financed mainly by the relatively well-to-do it continues in many cases to be administered mainly by them. In the areas described in detail in this survey the committees of the associations included either no working-class members or very few of them, with the sole exception of the Bloxham Association described in Chapter XV. On this matter I have little information with regard to the country as a whole, but my impression is that in many areas there are very

few working-class members of district nursing committees. However, there are areas in which this is not the case, especially those industrial districts where there are provident schemes whose members have considerable representation on the committee of the district nursing association which their scheme helps to finance.

There are probably several reasons for this absence of working-class committee members. As in most cases new committee members are in reality (though not in theory) appointed by co-optation, the names most likely to occur to existing members are those of persons in their ordinary circle of acquaintances. It may be thought good policy to invite large subscribers to become members of the committee. A fairly homogeneous committee is likely to work more smoothly, and it is tempting to take the line of least resistance in the matter. Also it is often difficult to find times of meeting which would suit working-class members. There is the difficulty that the work of the committees is of a kind with which many working-class people (and especially the women) are not familiar, and that it involves the appreciation of professional standards and of the point of view of professional workers. There is a further difficulty in small areas that patients may dislike their family and economic circumstances being known to their neighbours, while they have not so much objection to their being known to 'the gentry'.

But it is my opinion that it would be well worth while to try to overcome these difficulties, and to make the personnel of district nursing committees more representative of the varied classes and types of their supporters and more consistent with the universal appeal of the service and the increasingly democratic spirit of the present day. The committees would gain by the addition of a different kind of point of view and experience of life, and one which would be also that of the majority of the patients. The working-class members would gain insight into the problems of administration of a social service, which is a valuable part of the equipment of citizens.

It should be noted that this increased working-class representation in the administration of district nursing would not necessarily be achieved by a transference of the service to the administration of local authorities (discussed below).

It would occur in the case of local authorities with many working-class members, but in the case of many rural County Councils and Rural District Councils as well as in the case of some councils of small towns the working-class council members are very few.

If district nursing continues to be organized by voluntary associations an increase of working-class committee members will have to come about, in many cases, by the deliberate action of the committee. It cannot be left to the action of the subscribers assembled in the annual meeting because, as has been shown above, very few subscribers take the trouble to attend the annual meeting, and those who do very seldom take any independent action, preferring merely to confirm the action of the committee.

This administrative lethargy of the subscriber is very marked in the organization of district nursing, though probably not more marked than in the organization of other voluntary charitable associations. The subscriber, having given his contribution, takes little trouble to find out exactly how it has been spent (though he may often read the annual report), and he takes even less trouble to play any part in controlling its spending. Of course he has ways other than that of attending the annual meeting of judging of the general usefulness and efficiency of the service, but it is doubtful whether, in most cases, he would attend even if he had serious criticisms to make—he would be more likely to discontinue his subscription.

It is difficult to see how this state of affairs can be remedied. Something can be done by arranging for special speakers on topics of general interest, or for opportunities to see in practice some of the work of the association (as in the case of Hands-worth described in Chapter XIII). But, generally speaking, the annual meetings of charitable organizations are dull affairs except to those specially interested in the work described at them.

Thus district nursing is in practice administered by those with a special interest in it, appointed by their fellow-enthusiasts by a process of co-optation. If its organization were taken over by local authorities it would then be administered by a group of councillors (with possibly some co-opted

members) who might have a special interest in it but to whom it was only one of many functions for which they were elected by their constituents. In this case there would be genuine democratic control of the general activities of those councillors, but it is doubtful whether there would be much more control of their particular activities with regard to district nursing.

### SHOULD DISTRICT NURSING BECOME A PUBLIC SOCIAL SERVICE ?

It was argued in the first chapter of Section I of this book that on general principles the State, including local authorities, should make itself responsible for financing all essential health services. This argument implies that public authorities should pay the difference between the cost of these services and what the patients can afford to pay, either by payments at the time of illness or by contributions to compulsory or voluntary insurance schemes. As applied to district nursing the argument implies that public authorities, in addition to the grants made at present, should supply what is now supplied by charitable gifts of all kinds. (The amount of these gifts is at present probably about half a million pounds annually.) The capital assets of district nursing associations would presumably pass to the public authorities assuming their functions so that the income from interest would not be affected.

### ARGUMENTS IN FAVOUR OF THE ADMINISTRATION OF DISTRICT NURSING BY LOCAL AUTHORITIES

The arguments in favour of the transference of the present functions of district nursing associations to local authorities are, in my view, as follows

(1) There seems to be no distinction in principle between the service of district nursing and various health services which are at present publicly financed. If a patient's illness is of such a nature that he is admitted to a hospital under the public health committee or public assistance committee of the local authority, he is cared for by nurses employed and paid by that authority, if he remains at home the nurse attending

him is paid from charitable gifts in both cases he is asked to contribute to the cost if he is in a position to do so. Again, any patient who comes under the National Health Insurance Scheme, which is partly financed by the State, is entitled to the free attendance of a doctor, but he is not entitled (except in some cases as an 'additional benefit') to the attendance of a nurse, which may be as essential as the attendance of the doctor.

(2) There is urgent need for the further co-ordination of the country's health services. At present for the treatment of accident, illness, infirmity, and maternity there exist at least five public and two philanthropic systems in addition to the work of doctors, nurses, and midwives in private practice. These systems are (a) the National Health Insurance system, (b) the school medical service, (c) the local authority's hospitals, (d) the domiciliary service of poor law doctors, (e) the maternity and child welfare services of local authorities, (f) the voluntary hospitals (and in some places voluntary dispensaries also), (g) the district nursing associations. While some variety is desirable as furthering experiment, the present lack of co-ordination of these services is a hindrance to the best use of available medical and nursing skill for the benefit of the patient and to the development of a preventive health service. General district nursing should play an important part in a co-ordinated scheme of health services in assisting the doctor in cases treated at home and in the after-care of certain cases discharged from hospital. The importance of a subsidized midwifery service, at present provided by many district nursing associations, is recognized in the Midwives Act, 1936, and such a service should be co-ordinated with the work of the health visitors and ante-natal and infant welfare clinics, with the work of general practitioners, and with the work of maternity hospitals and gynaecological and obstetrical specialists. With regard to the provision of all branches of a co-ordinated health service the principle should be adopted that public authorities provide or arrange for the provision of all necessary services. Patients should contribute what they can afford and the balance should be provided from rates and taxes. (The problem of whether patients' contributions should be collected

by individual payments at the time of treatment or whether they are better provided by compulsory or voluntary insurance, with or without additional contributions from employers, falls outside the scope of this book, as it is a problem common to the finance of public and voluntary social services )

(3) District nursing is a service which appeals to the interest and support of all classes and sections of the population. This fact, while facilitating the financing of the service by voluntary gifts, also means that if the service were publicly financed it would have the willing support of most of the tax- and ratepayers

(4) While district nursing associations have been very successful in covering nearly the whole of the country with some amount of the service, and have provided an entirely adequate number of nurses in some places and an almost adequate number in others, yet the figures given on page 272 above show that at the end of 1934 there were still 23 per cent more nurses required in England and Wales as a whole. While in some areas the extra number of nurses required can probably be financed from voluntary sources there are other areas in which this will probably be very difficult

Voluntary finance will probably also fall short of what is required with regard to the qualifications and salaries of nurses in rural areas. If it is desirable, as was argued above, for nurses in rural areas to be as well qualified for general nursing work as the Queen's Nurses employed in towns, a considerable extra income will be required by rural nursing associations, and many of them will probably find it very difficult to raise. Also it seems probable that in the near future the legal minimum period of training for midwives will be increased, and this will involve an increased charge on those associations employing them unless the increased cost is met from public funds

#### ARGUMENTS AGAINST THE ADMINISTRATION OF DISTRICT NURSING BY LOCAL AUTHORITIES

On the other hand, there are, in my view, the following arguments against the transference of the present functions of district nursing associations to local authorities :

(1) District nursing associations have built up a large personnel of committee members and voluntary workers, many of whom have served for long periods and have acquired considerable knowledge and experience of the problems of district nursing and its organization. If district nursing were taken over entirely by the public health committee or the maternity and child welfare committee of the local authority many of those at present engaged in its administration would be lost to the service. (For example, there are at present about 280-290 members of district nursing committees in Birmingham and only about 20 members of the Public Health and Maternity and Child Welfare Committee of the City Council.) Without suggesting that all members of district nursing committees are valuable administrators, I would urge that to discontinue the work of many of them would be a great loss to the community. The present tendency to concentrate the work of voluntary administration on the relatively few members of the councils of local authorities, whatever may be the arguments in its favour from the point of view of efficiency and democratic control, is very wasteful as a method of utilizing the available capacities and goodwill of citizens. On the one hand, many councillors are badly overworked, on the other hand, many people who would willingly and capably participate in the administration of some social service are given no opportunities to do so. To hand over to public authorities our remaining voluntarily organized social services, without a considerable modification of our present system of public administration, would increase this wasteful concentration of administrative work upon the few.

There is one special point with regard to district nursing which emphasizes this argument. District nursing is at present largely administered by women, and, while it may not be desirable that women should figure so predominantly in its administration, it is a service with regard to which their experience and point of view is very valuable. In contrast to this position there are many local authorities with very few women councillors and some with none. The law requires that all maternity and child welfare committees shall include women members, but it is quite possible to find a



public health committee (as, for example, in Banbury at the present time) composed entirely of men

(2) The unit of organization of district nursing at present often corresponds more closely to the unit of local feeling and interest than does the unit of local government in the same area. In rural areas the district nursing association usually covers either one village or a group of neighbouring villages with some interest in each other's affairs. The rural district council, on the other hand, covers a much wider and less closely associated area, while the county council, which is responsible for many public health activities, is still further removed from the unit of local feeling. Unless some system of small local sub-committees were established, much local interest would be lost in the work of village nurses transferred to the employment of rural district or county councils. In urban areas this problem is not so important, but in large boroughs there might be a similar loss of interest if the work of district nursing associations with a system of local sub-committees were transferred to the borough council without any such system.

(3) A large number of district nursing associations have become co-ordinated in a national movement with a body of specialized knowledge. The early founding of the Queen's Institute, with affiliated associations in all parts of the country, and the early formation of county nursing federations, also affiliated to the Institute, to co-ordinate and further the work of rural associations, have meant that district nursing organization has long had a unity which, for example, the voluntary hospitals (outside London) have only begun to develop in recent years. This national service of information, advice, and stimulation might easily be lost to district nursing under local authorities unless either special care were taken to see that it was given by a department of the Ministry of Health or the present co-ordinating institutions were kept in existence for the purpose.

(4) The arguments in favour of substituting public for charitable finance are not nearly so strong in the case of district nursing as in the case of certain other social services at present under voluntary organizations. For example, district nursing associations have supplied the total need for domiciliary nursing much more adequately than the voluntary

hospitals have supplied the total need for hospital treatment, and they are not faced to nearly the same extent with the financial problem of the increase in the cost of the service due to extensions of medical knowledge. In some other cases of voluntarily organized social services the service exists only in certain districts—often only in the larger towns—and one advantage of administration by public authorities would be to universalize the service geographically. But some provision of district nursing is made in nearly all areas, though there are great differences between districts in both quantitative and qualitative adequacy of provision. It should be noted also that this difference would not necessarily be abolished if the service were administered by local authorities, as local authorities would differ in their financial resources and in their degree of enthusiasm for the service.

#### CONCLUSION

My conclusion, therefore, is that local authorities should give full recognition to district nursing as an essential part of the public health services, but that it is not necessary that they should assume complete control over it. They should use generously their existing powers to aid financially the work of district nursing associations, and particularly the additional powers given by the Midwives Act, 1936, and by Section 178 of the Public Health Act, 1936. They should regard themselves as responsible for ensuring that an adequate service—adequate in both quantity and quality—is provided. In cases in which an adequate service cannot be provided by voluntary associations they should themselves provide it, and the law should be altered so that they have power to do this. There should always be representatives of the public health (or other appropriate) committee of the local authority on the committees of all district nursing associations within its area. These representatives would have the function not only of helping to control the administration of the public grants to the association but also of keeping the local authority and the association in close touch with each other's work. My view is that if some such policy as this is pursued district nursing in this country can become in the near future a completely adequate service.



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